

FILED SEP 29 1955

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **30826**  
**7901**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. CITY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (In this place) <b>3 WKS.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>3501a Grace Ave.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>GEORGE</b>	b. (Middle) <b>C.</b>	c. (Last) <b>FEUCHT</b>	4. DATE DEATH (Month) (Day) (Year) <b>SEPT. 6, 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 22, 1882</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	Mis.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bowling</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>St. Anthony Alleys</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Smithton, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Jeanette Feucht</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>494-03-6622</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Lamina Feucht</b>	ADDRESS <b>3501a Grace Ave.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Right Pyiform Sinus (Larynx)</b>		<b>Months</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>Years</b>
DUE TO (c) <b>Carcinoma metastatic to lung.</b>		<b>Months</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **8-18-55**, 19\_\_\_, to **SEPT. 6,** 19**55**, that I last saw the deceased alive on **9-6-55**, 19\_\_\_, and that death occurred at **11:25a.**, from the causes and on the date stated above.

23a. SIGNATURE <b>John F. Orlinham</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	23c. DATE SIGNED <b>9-6-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept. 9, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery, St. Louis</b>	24d. LOCATION (City, town, or county) (State) <b>Missouri</b>
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DATE REC'D BY LOCAL REG. <b>SEP 8 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Hacker-Hellerle</b>	ADDRESS <b>3634 Gravois Ave.</b>
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3.0 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.