

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38149**
10590
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 3 hrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) 1229 McCausland Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) c. (Last) DEGENHARDT	4. DATE OF DEATH (Month) (Day) (Year) Dec. 1st 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 24th 1873	9. AGE (In years last birthday) 82.	IF UNDER 1 YEAR Months 6	IF UNDER 11 HRS. Days 7	IF UNDER 24 HRS. Hours	IF UNDER 1 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder	10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.				

13a. FATHER'S NAME Anton Degenhardt	13b. MOTHER'S MAIDEN NAME Elizabeth Kramer	14. NAME OF HUSBAND OR WIFE Elizabeth Degenhardt
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Louise Degenhardt	ADDRESS 1229 McCausland Ave
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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 6 mos. 3 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Severe atherosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severely atherosclerosis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 420.0	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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **9-2**, **1954**, to **12-1**, **1955**, that I last saw the deceased alive on **12-1**, **1955**, and that death occurred at **6-9** p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. B. Gummel, M.D.	23b. ADDRESS 1116 McCausland	23c. DATE SIGNED 12-2-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Dec 5-1955	24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem. St. Louis Mo	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. DEC 3 1955	REGISTRAR'S SIGNATURE J. Carl Smith	FUNERAL DIRECTOR'S SIGNATURE W. H. Doolittle	ADDRESS 6536 Clayton Rd
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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
Student Embalmer

Signed

Paul A. Kadler

Licensed Embalmer No. *4787*

P. O. Address

St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.