

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 38228BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10365

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	c. LENGTH OF STAY (in this place) <u>3yrs</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5962 McArthur Avenue</u>		e. STREET ADDRESS (If rural, give location) <u>5962 McArthur Avenue</u> ²⁰⁷⁹	
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) c. (Last) <u>Figart</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 - 26 - 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11 - 10 - 1891</u>
9. AGE (in years last birthday) <u>64</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Monsanto Chem. Co.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Altoona, Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Daniel B. Figart</u>	
13b. MOTHER'S MAIDEN NAME <u>Anna Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Elda Figart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>493-05-4384</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Elda Figart</u>		ADDRESS <u>5962 McArthur Ave.</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular Occlusion Sudden</u> ANTECEDENT CAUSES <u>Generalized arteriosclerosis years.</u> DUE TO (b) <u>Myocardial Damage</u> DUE TO (c) <u>2yrs.</u> 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 <u>332X - 4500</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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)		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 <u>3/13</u> , 19 <u>53</u> , to <u>11/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/21</u> , 19 <u>55</u> and that death occurred at <u>11A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Robert A. Bauer M.D.</u>		23b. ADDRESS <u>3731 Goodfellow</u>	
23c. DATE SIGNED <u>11/28/55</u>		24. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24b. DATE <u>11/30/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Drehmann-Harral</u>	
DATE REC'D BY LOCAL REG. <u>NOV 28 1955</u>		ADDRESS <u>1905 Union Blvd.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Robt. A. Bauer
3731 Goodfellow Ave.
1 - 3 Nov & Tue

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.. *Warren A. Carve*

Licensed Embalmer No. *353*

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.