

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41973**
Registrar's No. **11554**

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 Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place) _____	c. CITY OR TOWN St. Louis	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 Lutheran Hospital		e. STREET ADDRESS (If rural, give location) 4248 Flora Pl	21790

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) J c. (Last) Decker Sr.	4. DATE OF DEATH (Month) (Day) (Year) Dec 30 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 25 1871	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief clerk Collectors Office City St. L.	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo	12. CITIZENRY OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Frideline Decker	13b. MOTHER'S MAIDEN NAME Caroline Buenzon	14. NAME OF HUSBAND OR WIFE Mary Mulcahy Decker
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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 Myrtle M Decker ADDRESS 4248 Flora Pl
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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) Fa. of right Femur.		10 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Ar. V. Sclerosis. 10 yrs. DUE TO (c) Hyp. Per stroke. 5 yrs.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. cystitis			2 mos.

19a. DATE OF OPERATION 12. 23. 56.	19b. MAJOR FINDINGS OF OPERATION Fa. of head of right Femur.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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.) Home.	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12. 23. 1956. 1A.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall on his back. 904.0
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22. I hereby certify that I attended the deceased from **12. 20, 1955**, to **12/27, 1955**, that I last saw the deceased alive on **12/29, 1955**, and that death occurred at **1:10A m.**, from the causes and on the date stated above.

23a. SIGNATURE Dr. H. H. Probst (Degree or title) MD	23b. ADDRESS 1504 So Grand	23c. DATE SIGNED 12. 30. 56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 2 1956	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE REC'D BY LOCAL REG. DEC 30 1955	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schnur ADDRESS 3125 Lafayette
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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 *Jon B. Vallmu*.....

Licensed Embalmer No. *4014*
P. O. Address *395 Lafayette*

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