

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18269

State File No. \_\_\_\_\_

FILED JUN 11 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4180**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>7 hrs.</b>	c. CITY OR TOWN <b>Afton</b> <b>4890</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Alexian Brothers Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>10301 Baptist Church Road</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>George</b>	b. (Middle) <b>A.</b>	c. (Last) <b>Maas</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 25, 1956</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>Feb. 4, 1894</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Johnson Stephens &amp; Shankle</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Maas</b>	13b. MOTHER'S MAIDEN NAME <b>Josephine Schnitzler</b>	14. NAME OF HUSBAND OR WIFE <b>Sophia Norrenberns Maas</b>
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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) <b>Yes W.W. #1</b>	16. SOCIAL SECURITY <b>492-01-8828</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Sophia Maas-10301 Baptist Ch Rd</b>	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>		
	ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____		
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 <b>420.</b>	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 **4/25/56**, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on **4/25/56**, 19\_\_\_\_, and that death occurred at **5:30 P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>W. W. Eades M.D.</b> (Degree or title)	23b. ADDRESS <b>7602 So. Broadway</b>	23c. DATE SIGNED <b>4/26/56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Apr. 30, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>APR 27 1956</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Wacker - Hellerle</b>	ADDRESS <b>3634 Gravois Ave.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

b. 300  
0. 48

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.....  
*Frank J. Glavin*

Licensed Embalmer No.....  
*26*

P. O. Address.....  
*W. Linn*

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.