

FILED SEP 6 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28839**  
Registrar's No. **7575**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7575</b>	
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 <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		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 <b>DePaul Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>2328a No. Union Blvd.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Eva</b> b. (Middle) _____ c. (Last) <b>Metzger</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 14 1956</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>Apr. 29 1896</b>		9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Kinmundy Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Metzger</b>		13b. MOTHER'S MAIDEN NAME <b>Lilly Krutzinger</b>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Carl Metzger Belleville Ill.</b>			
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) <b>Carcinoma of Lung</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Carcinoma of Bronchus</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arterian Hypertension 163+</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Nov 1955</b> " "	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>No operation other than Shavecutting</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <b>March</b> , 1956, to <b>Aug</b> , 1956, that I last saw the deceased alive on <b>Aug 13</b> , 1956 and that death occurred at <b>10:00A.M.</b> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>John B. Keyes M.D.</b>				23b. ADDRESS <b>3903 Olive St.</b>		23c. DATE SIGNED <b>Aug 15 1956</b>	
24a. BYEVAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>8/15/56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Kinmundy Ill</b>		24d. LOCATION (City, town, or county) (State) <b>Kinmundy Ill</b>	
DATE REC'D BY LOCAL REG. <b>AUG 15 1956</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Sullivan's 2849 No. Euclid Ave.</b>			

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

Dr. J. D. Meyer  
The Public Health

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.....  
*Albert Grayfield*

Licensed Embalmer No. 307

P. O. Address.....

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.