

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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28847

State File No. ....

Registrar's No. 6654

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		REGISTRAR'S NO. _____	
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. 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 checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>CHRISTIAN HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>4646 KOSSUTH AVE</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>EDWARD</b>		b. (Middle) <b>H.</b>		c. (Last) <b>MILBRATZ</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 14, 1956</b>	
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>11/13/1888</b>	
9. AGE (In years last birthday) <b>67</b>		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) <b>CHAUFFEUR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>COLUMBIA TERMINALS</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>ST LOUIS MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13a. FATHER'S NAME <b>CHARLES MILBRATZ</b>		13b. MOTHER'S MAIDEN NAME <b>JOHANNA CORNELL</b>		14. NAME OF HUSBAND OR WIFE <b>MILISS MILBRATZ</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>#489-05-1500</b>		17. INFORMANT'S SIGNATURE OR NAME <b>MILISS MILBRATZ</b> ADDRESS <b>4646 KOSSUTH AVE</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, ashenia, 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 Bladder and Prostate with metastases.</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>5-8-56</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Bladder and prostate with metastases</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>4-27-56</b> , 19____, to <b>7-14-56</b> , 19____, that I last saw the deceased alive on <b>7-14-56</b> , 19____, and that death occurred at <b>1:30 P.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>607 N. Grand, St. Louis, Mo.</b>		23c. DATE SIGNED <b>7-16-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>7/17/56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>ST LOUIS MISSOURI</b>	
DATE REC'D BY LOCAL REG. <b>JUL 16 1956</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>STROOT - CARROLL 4600 NATURAL BRIDGE AVE</b>			

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

Primary file date

**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..... *M. W. R. Peter*

Licensed Embalmer No. *4863*

P. O. Address *St. Louis*

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.