

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42640

FILED JAN 15 1957

Registration District No. 318 Primary Registration District No. 1003 STATE FILE NUMBER 11922

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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

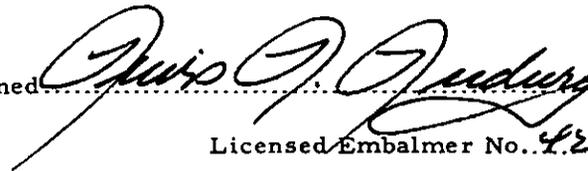
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|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5843 Cabanne</u> | | Length of stay in lb | STREET ADDRESS <u>5843 Cabanne</u> | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>MAURICE</u> Middle <u>L.</u> Last <u>BACH</u> | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1956</u> | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 5, 1901</u> | 9. AGE (In years last birthday) <u>55</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor</u> | 11. BIRTHPLACE (City and state or country) <u>New York, N. Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>(unk) Bach</u> | | | 14. MOTHER'S MAIDEN NAME <u>Hannah (unk)</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW 1</u> | | 16. SOCIAL SECURITY NO. <u>(LINK)</u> | 17. INFORMANT Address <u>Mrs. R. Bach 5843 Cabanne</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease -</u> <u>Acute Coronary Occlusion -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mos. 30 mins.</u> |
| 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>420.0</u> | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ <u>9 p.m.</u> | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | | COUNTY _____ STATE _____ |
| 21. I attended the deceased from <u>Oct. 15 - 56</u> to <u>12-27-56</u> and last saw ^{her} _{him} alive on <u>12-26-56</u> Death occurred at _____ <u>1 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>John J. Hammond M.D.</u> (Degree or title) | | | 22b. ADDRESS <u>634 N. Grand</u> | | 22c. DATE SIGNED <u>12/27/56</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | | 23b. DATE <u>12/28/56</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>B'Nai Amoona Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Univ. City, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Berger Memorial 4715 McPherson</u> | | | 25. DATE RECD. BY LOCAL REG. <u>DEC 27 1956</u> | | 26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>m 83</u> |

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.....



Licensed Embalmer No. 42

P. O. Address

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