

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42825

STATE FILE NUMBER

FILED DEC 18 1956

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10774**

health, Welfare, Public Service  
 300  
 1-56  
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. ANTHONY'S Hosp.</b>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>3521 GRACE</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT W.</b> Middle <b>CASH</b> Last <b>SR.</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1956</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 10 1916</b>	9. AGE (In years last birthday) <b>39</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WOODWARD-TIERMAN</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM CASH</b>			14. MOTHER'S MAIDEN NAME <b>EMMA BUCHER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WAR II</b>		16. SOCIAL SECURITY NO. <b>494-10-9310</b>		17. INFORMANT Address <b>DOROTHY CASH 3521 GRACE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>420.1</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____					
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 <b>October 22-26</b> , to <b>11-23-56</b> and last saw her alive on <b>11-23-56</b> Death occurred at <b>11-23-56 11:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or title) <b>John D. Seret M.D.</b>			22b. ADDRESS <b>3739 Gravois</b>		22c. DATE SIGNED <b>11-24-56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>Nov. 26 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL CHURCHYARD</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>
24. FUNERAL DIRECTOR <b>Thomas Kuter 2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 26 1956</b>		26. REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b> <i>m. g. B.</i>	

(Licensed Embalmer's Statement on Reverse Side)

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. ....

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.