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FILED JUN 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19187

STATE FILE NUMBER 5225

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

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand St. Louis, Mo. — Inside Limits Yes X No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL — Length of stay in Hospital 24 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes X No
STREET ADDRESS 3434 Montana (If outside, give location) — Reside on Farm Yes No X

3. NAME OF DECEASED (Type or print): First COEN Middle H. Last RADCLIFFE

4. DATE OF DEATH Month 6 Day 3 Year 57

5. SEX MALE **6. COLOR OR RACE** WHITE **7. MARRIED** X **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH 9/24/97

9. AGE (In years last birthday) 59 yrs. — 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) CLERK
10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN
11. BIRTHPLACE (City and state or country) MARENGO INDIANA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Zachary Radcliffe
14. MOTHER'S MAIDEN NAME Sarah Harvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-1
16. SOCIAL SECURITY NO. 495-12-2968
17. INFORMANT V. A. HOSPITAL RECORDS Address ST. LOUIS, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH 6 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) CARCINOMA OF LUNG — UNK
DUE TO (c) — — — 163x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — — —

19. WAS AUTOPSY PERFORMED? YES ☐ NO X 2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐ NONE
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 5/10/57, to 6/3/57 and last saw him alive on 6/3/57
Death occurred at 9:50 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. T. Kaminskas (Degree or Title) M.D.
22b. ADDRESS VA HOSPITAL ST. LOUIS 6 MO.
22c. DATE SIGNED 6/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE June 6/57
23c. NAME OF CEMETERY OR CREMATORY National Cemetery
23d. LOCATION (City, town, or county) (State) Jeff. Brks. Mo.

24. FUNERAL DIRECTOR Fendler Und. Co. **ADDRESS** 7420 Michigan
25. DATE RECD. BY LOCAL REG. JUN 4 '57
26. REGISTRAR'S SIGNATURE J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. G. Peterson

Licensed Embalmer No. 3

P. O. Address 7420 M

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.