

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29219**
Registrar's No. **7943**

FILED SEP 4 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. LENGTH OF STAY (In this place) 2 WKS.		c. CITY OR TOWN ST. LOUIS		
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital #1		e. STREET ADDRESS (If rural, give location) 3417 1/2 Union				
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) JACOB c. (Last) Bishop			4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1957			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		
8. DATE OF BIRTH JUN 17 1873		9. AGE (In years last birthday) 84		10. IF UNDER 1 YEAR: Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (City and State or Foreign Country) Browning, Illinois		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Bishop		13b. MOTHER'S MAIDEN NAME UNKNOWN		
14. NAME OF HUSBAND OR WIFE Lottie Thomas		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 498-16-5506		
17. INFORMANT'S SIGNATURE OR NAME Mrs Frank Paul		18. ADDRESS 3417 1/2 Union St. St. Louis		19. MEDICAL CERTIFICATION		
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema				INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		DUE TO (b) Arterio sclerotic heart disease.				
		DUE TO (c) Uremia.				
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.		420.0				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY? 2 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) (Min.)		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 AUG 12, 1957 , to AUG 25, 1957 , that I last saw the deceased alive on AUG 25, 1957 , and that death occurred at 8:30 a.m. , from the causes and on the date stated above.				
23a. SIGNATURE Martin H Meyer M.D.		23b. ADDRESS St. Louis City Hosp #1		23c. DATE SIGNED 8/25/57		
24a. FUNERAL, CREMATION, REMOVAL (Specify)		24b. DATE Aug 25 57		24c. NAME OF CEMETERY OR CREMATORY Masontal City		
24d. LOCATION (City, town, or county) (State) Masontal, Ill.		DATE REC'D BY LOCAL REG. AUG 26 57		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		
25. FUNERAL DIRECTOR'S SIGNATURE Geo Renner		ADDRESS Belleville, Ill.				

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

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 *Geo. Bennett*.....

Licensed Embalmer No. *2031*
P. O. Address *Belleville*.....

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.