

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

FILED AUG 30 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

29763
 STATE FILE NUMBER
 1003
 Registrar's No. 7196

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7196

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Clayton		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.				Length of stay in 1b 2 months		d. STREET ADDRESS (If outside, give location) 6401 Alamo Ave.		
3. NAME OF DECEASED (Type or print) THEODORE A MAUL				First Middle Last		4. DATE OF DEATH July 31st 1957		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6 1884		
9. AGE (In years last birthday) 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Public Acct.		10b. KIND OF BUSINESS OR INDUSTRY Price Waterhouse		11. BIRTHPLACE (City and state or country) Alton, Ill.		
13. FATHER'S NAME Joseph Maul				14. MOTHER'S MAIDEN NAME Carline Arens				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes Navy		16. SOCIAL SECURITY NO.		17. INFORMANT Address David Maul 8729 Norcross Dr.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastases from carcinoma of prostate DUE TO (b) 177X 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 2 yrs 7 yrs	
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. Month, Day, Year								
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 10 May 57 to 31 July 57 and last saw ^{her} him alive on 31 July 57 Death occurred at 1130 P on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Paul Barrow MD				22b. ADDRESS 110 S. Central Clayton		22c. DATE SIGNED 2 Aug 57		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug. 3 1957		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo		
24. FUNERAL DIRECTOR ADDRESS A. H. Bocklage 6536 Clayton Rd.			25. DATE RECD. BY LOCAL REG. AUG 2 '57		26. REGISTRAR'S SIGNATURE Paul Smith MD mdb			

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 *Elmer P. Gardner*.....

Licensed Embalmer No. *40*.....

P. O. Address *St. Louis*.....

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.