

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38706

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2540

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Florissant</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Florissant</u> <u>4000</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ROUTE #2, Box 148 INSTITUTION <u>Highway #140</u>		Length of stay in lb <u>1 year</u>	d. STREET ADDRESS (If outside, give location) <u>Route #2 Box 148</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Louis</u>		First	Middle
		Last	(<u>Highway #140</u>) Month Day Year DEATH <u>October 12 1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teamster (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	9. AGE (In years last birthday) <u>86</u>
11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	IF UNDER 1 YEAR Months Days Hours Min.
13a. FATHER'S NAME <u>Henry Drees</u>		13b. MOTHER'S MAIDEN NAME <u>Henrietta - 4215.</u>	14. NAME OF HUSBAND OR WIFE <u>Sophia Drees (Deceased)</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs. Mabel Hackmann, Route #2, Florissant, Mo</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>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			<u>4200</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year 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 <u>July 1957</u> to <u>Oct 12, 1957</u> and last saw her alive on <u>Oct 11, 1957</u> Death occurred at <u>11:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M D Johnson M D</u> (Degree or title)		22b. ADDRESS <u>Ferguson Mo</u>	22c. DATE SIGNED <u>10-14-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 15 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>		(State)	
24. FUNERAL-DIRECTOR ADDRESS <u>Math Hermann & Son, Inc, 2161 E. Fair Av</u>		25. DATE RECD. BY LOCAL REG. <u>10-14-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke MD</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Welford K. Bussley*
Licensed Embalmer No. *4202*
P. O. Address *St. Louis, Mo.*

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.