

pt. Health, XC-2737504 SLL3013
 & Welfare
 S. Public
 th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45777
 STATE FILE NUMBER
 Registrar's **12081**

FILED DEC 30 1957

Registration District No. **318** Primary Registration District No. **1003**

S. 300
 v. 1-57

| | | | | | | | | |
|---|-------------------------------|---|--|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY ST. LOUIS | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN ST. LOUIS | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL | | Length of stay in lb 16 Days | | d. STREET ADDRESS (If outside, give location) 3638 DE TONTY ST | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First LEONIDAS Middle C Last DYER | | | | 4. DATE OF DEATH Month 12- Day 15- Year 57 | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-11-71 | | 9. AGE (In years last birthday) 86 IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER - Self Employed | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) WARREN COUNTY, MO | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME JAMES C DYER | | | 13b. MOTHER'S MAIDEN NAME MARTHA E. CAMP | | 14. NAME OF HUSBAND OR WIFE CLARA H DYER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES SPAW | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address VAH.RECORDS 915 N.GRAND ST.LOUIS, MO. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 420.0 | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 YEARS | | |
| 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 <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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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. <input checked="" type="checkbox"/> attended the deceased from 11-29-57 to 12-15-57 and last saw <input checked="" type="checkbox"/> alive on 12-15-57 Death occurred at 9:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>Thomas L. Wright</i> THOMAS L. WRIGHT | | | | 22b. ADDRESS M.D. VAH ST.LOUIS, MO. | | 22c. DATE SIGNED 12-15-57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Dec. 18, 1957 | 23c. NAME OF CEMETERY OR CREMATORY. Oak Grove Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S.Kingshighway | | | 25. DATE RECD. BY LOCAL REG. DEC 16 57 | | 26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> m88 | | | |

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 *Edwin H. C. Bennett*

Licensed Embalmer No.
P. O. Address

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.