

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 46059

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11997

|   |                        |   |  |  |  |
|---|------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE MISSOURI b. COUNTY ST. LOUIS   |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN ST. LOUIS  |                        | c. LENGTH OF STAY (in this place) 4 DAYS  |  | c. CITY OR TOWN 400P FLORISSANT  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 14 JEWISH HOSPITAL  |                        | e. STREET ADDRESS (If rural, give location) 27 31 FLORVAL DRIVE   |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) HENRY b. (Middle) DE BALD c. (Last) LOCKWOOD  |                        | 4. DATE OF DEATH (Month) (Day) (Year)<br>DEC. 11 1957   |  |  |  |
| 5. SEX M  | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED  | 8. DATE OF BIRTH APRIL 23, 1909                                  | 9. AGE (In years last birthday) 48   | IF UNDER 1 YEAR Months Days  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOP FOUNDRY FOREMAN  |                        | 10b. KIND OF BUSINESS OR INDUSTRY AMERICAN BRAKE  | 11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO |  | 12. CITIZEN OF WHAT COUNTRY? USA   |
| 13a. FATHER'S NAME FRANK LOCKWOOD   |                        | 13b. MOTHER'S MAIDEN NAME LYDIA McCLURE   |  | 14. NAME OF HUSBAND OR WIFE EVA LOCKWOOD   |  |
| 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. 497-09-0215   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS EVA LOCKWOOD, FLORISSANT, Mo.          |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |                        | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Insufficiency<br>ANTECEDENT CAUSES<br>DUE TO (b) Pneumonia, Right.<br>DUE TO (c) Right Heart Failure<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. Emphysema |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>12 HRS<br>6 Days<br>12 HRS<br>3 1/2 HRS. |
| 19a. DATE OF OPERATION  |                        | 19b. MAJOR FINDINGS OF OPERATION 493+   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) None   |                        | 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)   |                        | 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 8-30-1955 to 12-11, 1957, that I last saw the deceased alive on 12-10, 1957, and that death occurred at 8:20 a.m., from the causes and on the date stated above.       |                        |   |  |  |  |
| 23a. SIGNATURE A. J. Steiner  |                        | 23b. ADDRESS (Degree or title) MD 3903 Olive Street   |  | 23c. DATE SIGNED 12/13/57  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL   |                        | 24b. DATE 12-14-1957  |  | 24c. NAME OF CEMETERY OR CREMATORY LAUREL HILL MEM. GARDENS                      |  |
| 24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.   |                        | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gene H. Hutchens, FLORISSANT, Mo.  |  |  |  |
| DATE REC'D BY LOCAL DEC 13 '57  |                        | REGISTRAR'S SIGNATURE J. Paul Smith, M.D.<br>M. J. B.   |  | (Licensed Embalmer's Statement on Reverse Side)                                  |  |

WRITE PLAINLY—USING UNFADING 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.....  
*Gene D. Satchers*

Licensed Embalmer No. *4966*

P. O. Address *Albion*

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.