

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015566
STATE FILE NUMBER
2 2812

FILED MAY 1 1959 Registration District No. Primary Registration District No. Registrar No.

300
1-57
7 3
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 1624 S. Compton Ave.	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last LOUIS M. PRADE			4. DATE OF DEATH Month Day Year Mar. 18 1959		
---	--	--	--	--	--

5. SEX Male <input checked="" type="checkbox"/>	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 July 17, 1887	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--	---------------------------	---	-----------------------------------	---------------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired) Recorders Office	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Phil. Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	--

13a. FATHER'S NAME Louis Prade	13b. MOTHER'S MAIDEN NAME Ellen Shea	14. NAME OF HUSBAND OR WIFE Late Ione Prade
-----------------------------------	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. 486-18-9467a	17. INFORMANT Jack Prade 2316 St. Clair	Address Brentwood, 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) <u>Coronary Occlusion</u> <u>Coronary Sclerosis</u> 420.1		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
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 WORK <input type="checkbox"/> NOT 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 _____ to _____ and last saw her alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Patrick F. Taylor</u>	(Degree or title) Council 1300 Clark	22b. ADDRESS	22c. DATE SIGNED 3. 19. 59.
--	---	--------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 20, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	----------------------------	--	---

24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway	ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 19 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
---	---------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

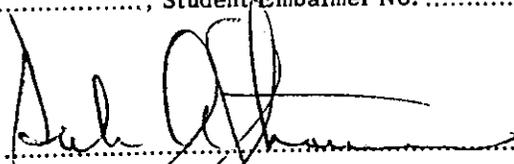
All diseases in Part I must be causally related.

mj B.

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 

Licensed Embalmer No. 4533

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.