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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Not legible - use of medical information

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019256
State File No. 2 4412
Registrar's No.

FILED MAY 25 1959

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 11 mths		c. CITY (If outside corporate limits, write RURAL and give township) Clayton 4000			
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda Hospital		d. STREET ADDRESS (If rural, give location) 415 Louwen Drive					
3. NAME OF DECEASED (Type or Print) a. (First) CHRISTOPHER		b. (Middle)		c. (Last) HONIG			
4. DATE OF DEATH May 4th 1959		5. SEX Male		6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH May 15, 1958		9. AGE (In years last birthday) IF UNDER 1 YEAR 11 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Harry Honig		13b. MOTHER'S MAIDEN NAME Ellen Jane Ahlshire			
14. NAME OF HUSBAND OR WIFE		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. none			
17. INFORMANT'S SIGNATURE OR NAME Harry Honig		ADDRESS 1002 W. Adams Ave.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Breach pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Encephalopathy Congenital - DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 752x				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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 <u>Sept 19-29</u> , to <u>May 4</u> , 1959, that I last saw the deceased alive on <u>May 4</u> , 1959, and that death occurred at <u>11:40 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE Ralph E. Cook M.D.		23b. ADDRESS 508 N. Grand -		23c. DATE SIGNED May 5 '59			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 5, 1959		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem.			
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE A.H. Bocklage					
DATE REC'D BY LOCAL REG. MAY 5 '59		REGISTRAR'S SIGNATURE Loan Smith, M.D.		ADDRESS 6536 Clayton Rd.			

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
Student Embalmer

Signed.....

Not Embalmed
J. H. Becklage

..... Licensed Embalmer No.

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.