

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027046

FILED VS JUL 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6501** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			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		Length of stay in 1b 68 yrs	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3829 California Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First: HENRY Middle: A. Last: PAUL			4. DATE OF DEATH Month July Day 7 Year 1959		
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 8/1/1890	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) interior decorator		10b. KIND OF BUSINESS OR INDUSTRY Paper Hanging-Ptg		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Henry A. Paul		13b. MOTHER'S MAIDEN NAME Anna Geitz	
14. NAME OF HUSBAND OR WIFE Cora Gasper		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.	
17. INFORMANT Address Mrs. Cora Paul, 3829 California Avenue		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured left ventricle Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) myocardial infarction DUE TO (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH immediate 2 days 5 years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 4200			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 July 5 to July 7, 1959 and last saw him alive on July 7, 1959 Death occurred at 6:28 P. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Albert J. Grude MD (Degree or title)		22b. ADDRESS 3606 Grannis		22c. DATE SIGNED 7-8-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE July 10, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Paul Churchyard		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. JUL 9 59		26. REGISTRAR'S SIGNATURE Neal Smith M.D.	

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Albert Gnade
3606 Gravois Avenue
1-4 PM - no thurs.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 45

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.