

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033277

FILED VS SEP 1960 **317** Primary Registration District No. **547** Registrar's No. **2548** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Length of stay in lb 22 days	c. CITY OR TOWN Richmond Heights Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7685 Lindbergh Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CHARLES JULIUS QUADE			4. DATE OF DEATH Month Day Year August 26, 1960			
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 Nov. 7, 1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 9 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Div. Manager Ret.		10b. KIND OF BUSINESS OR INDUSTRY Ely & Walker Dry Goods, St. Charles, Mo		11. BIRTHPLACE (City and state or country) U. S. A.		
13a. FATHER'S NAME Charles George Quade		13b. MOTHER'S MAIDEN NAME Julia Barklage		14. NAME OF HUSBAND OR WIFE Josie Wondracheck Quade		
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. 494-09-9736		17. INFORMANT Address Josie Quade, 7685 Lindbergh Drive		

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			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease			
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Coronary arteriosclerosis		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	
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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 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 **11/29/1955** to **Aug. 26, 1960** and last saw him **live** on **Aug. 26, 1960**
Death occurred at **6:40 Pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thermon W. Parker M.D.		22b. ADDRESS 4660 Maryland St. St. Louis, Mo		22c. DATE SIGNED 8/27/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 29, 1960	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	23d. LOCATION (City, town, or county) (State) St. Charles, Missouri	
24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd.		25. DATE RECD. BY LOCAL REG. 8-29-60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

A. J. Lawrence

Licensed Embalmer No. *478*

P. O. Address *St. Louis*

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.