MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 447 61-007110 STATE FILE NUMBER

FILED VS MAR 2 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Length of stay in 1b: 19 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Florissant — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1010 Charbonier Rd — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: WILLIAM Middle: Last: DRAGER
4. DATE OF DEATH Month Day Year: Feb. 11, 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: April 1886
9. AGE (last birthday): 74 — 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): Beer Bottler
10b. KIND OF BUSINESS OR INDUSTRY: Brewing
11. BIRTHPLACE (City and state or country): St. Louis Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Olive Drager
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
17. INFORMANT: Mrs Olive Drager Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia right lung with abcess — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
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): Chronic Pyelonephritis - Cystitis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1-23-1961 to 2-11-1961 and last saw her/him alive on 2-11-1961
Death occurred at 2-11-1961 5:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul W. Schaper M.D.
22b. ADDRESS 601 S. Brentwood, Clayton, Mo.
22c. DATE SIGNED 2/12/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-14-1961
23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County

24. FUNERAL DIRECTOR The Florissant Mortuary — ADDRESS Florissant, Mo
25. DATE RECD. BY LOCAL REG. 2-13-61
26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | DOCUMENT | SHOULD READ | BY AFFIDAVIT OF | ITEM NO.

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 Hutchins

Licensed Embalmer No. 4966

P. O. Address Florissant, Mo.

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.