S. No. 2
M—8-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 15 1944 318

Registration District No. .....

Primary Registration District No. 1003

State File No. 35809

Registrar's No. 10450

1. PLACE OF DEATH:

(a) County .....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community .....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County .....

(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")

(d) Street No. 4526 Page
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Christian Edward Droste

3. (b) If veteran, name war .....

3. (c) Social Security No. --

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Annie Dupont Droste

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased October (Month) 25 (Day) 1866 (Year)

8. AGE:

Years	Months	Days	If less than one day
78	1	10	..... hr. ..... min.

9. Birthplace Washington Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation Key maker

11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace ,, (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace ,, (City, town, or county) 0 (State or foreign country)

16. (a) Informant Mo. Baptist Hospital

(b) Address .....

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (Month) 5 (Day) 44 (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director Drehmann Harral

(b) Address 1905 Union blvd.

19. (a) DEC 7 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5
year 1944 hour 5 minute 05 P M.

21. I hereby certify that I attended the deceased from Dec 5 am, 1944, to Dec 5 pm, 1944
that I last saw him alive on Dec 5, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uraemia (N-PN 154)	few days
Due to Carcinoma of Prostate with Complete retention of urine	few years
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —
(Specify type of place)

While at work? — (e) Means of injury .....

23. Signature C. C. Bradford 0 (M. D. or other)

Address 958 Arcade Bldg Date signed 11/7/44

(Licensed Embalmer's Statement on Reverse Side)

O. C. E. Bisford
Oxcode Mfg

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Warren A. Carver

Licensed Embalmer No. 3534

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