

No. 2
5-43
5-17-39
X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 9 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34965
State File No. _____
Registrar's No. 2508

Registration District No. 317 Primary Registration District No. 3069

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Richmond Heights.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)
(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 St. Louis 96
(c) City or town Clayton
(If outside city or town limits, write "RURAL")
(d) Street No. 6336 Forsythe Blvd.,
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CASPER PETER DeLORE.
3. (b) If veteran, no name war. 3. (c) Social Security No. no
4. Sex Male 0 5. Color or race White
6. (a) Single, widowed, married, divorced / Married.
6. (b) Name of husband or wife Amalia A. DeLore.
6. (c) Age of husband or wife if alive. ? years
7. Birth date of deceased Sept. 14 1880
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 29
year 1948 hour 3:00 minute A. M.
21. I hereby certify that I attended the deceased from July seventh, 1948, to October 28, 1948, that I last saw him alive on Oct. 28th, 1948, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
68 1 15 hr. min.

Immediate cause of death
Acute cardiac failure
Due to Chronic Pyelo-Nephrosis & Nephritis
Due to General arterio-sclerosis
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 1318

9. Birthplace St. Louis, Mo. 0
(City, town, or county) (State or foreign country)
10. Usual occupation Retired; DeLore Division,
National Lead Co.
11. Industry or business

PHYSICIAN
Underline the cause to which death should be charged anatomically.
Of autopsy: Bilateral Pyelo-Nephrosis - Nephritis, Chronic Myocarditis, Art. Sclerosis

MOTHER FATHER
12. Name Anthony A. DeLore.
13. Birthplace St. Louis, Mo. 0
(City, town, or county) (State or foreign country)
14. Maiden name Katherine M. Gockel.
15. Birthplace St. Louis, Missouri. 0
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mrs. Amalia A. DeLore.
(b) Address 6336 Forsythe Blvd.,
(c) Place: burial or cremation Oak Grove Mausoleum.
17. (a) Entombment (b) Date thereof Nov. 1 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation

While at work (Specify type of place) (a) Means of Injury 0
23. Signature Geo. H. Mathae (M. D. or other)
Address 3167 So. Grand Blvd. Date signed 10/27/48

18. (a) Signature of funeral director C.R. Lupton & Sons.
(b) Address 7233 Delmar Blvd.,
19. (a) 10-29-48 (b) Cecil C. Sharp
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

4/6/60
P.O. = 52/73
3:30 - 4
Mary Hand

Dr. George Mattias
3167 S. Grand
L.A. 5042

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 Arnold W. Schaene
Licensed Embalmer No. 3864
P. O. Address St Louis - 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 this body is not embalmed, fact should be so stated above.