

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

No. 300
10.48

FILED AUG 2 1949

State File No. **85542**

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 2002		Registrar's No. 1825	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY St. Louis				a. STATE Mo.			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		_____	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7311 LINDELL AV. 1				d. STREET ADDRESS (If rural, give location) 7311 LINDELL A			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) John			b. (Middle) ALBERT			c. (Last) DAYGER	
(Type or Print)			Month JULY Day 19 Year 49				
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
MALE		WHITE		WIDOWER		JUNE-17-1887	
9. AGE (In years less birthday) 62 YRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL		11. BIRTHPLACE (State or foreign country) LION-HERKIMER CTY. N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME WARNER-DAYGER			13b. MOTHER'S MAIDEN NAME MARGARET GRIM			14. NAME OF SPOUSE OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Audrey Dayger GASS		ADDRESS 7311 LINDELL	
18. CAUSE OF DEATH				MEDICAL CERTIFICATION			
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) art. sclerotic nose disease and stenosis			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES			
				Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
				DUE TO (b) _____			
				DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 19, 1949 to July 19, 1949 , that I last saw the deceased alive on July 17, 1949 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) Wayne O. Smith M.D.				23b. ADDRESS 2730 N. Grand		23c. DATE SIGNED 7-20-49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE July 21-49		24c. NAME OF CEMETERY OR CREMATORY Unknown		24d. LOCATION (City, town, or county) (State) WARREN PENNSYLVANIA	
DATE REC'D BY LOCAL REG. 7-22-49		REGISTRAR'S SIGNATURE Herbert R. ...		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schurer		ADDRESS 3125 Lafayette Av	

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

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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
Student Embalmer

Signed

Joseph B. Vollmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette*

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.