

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 17 1949

No. 300  
10.48

BIRTH NO. 52382-48 REG. DIST. NO. 617 PRIMARY REG. DIST. NO. 3069 Registrar's No. 1925

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

1. PLACE OF DEATH a. COUNTY <u>ST. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>10</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>	
c. LENGTH OF STAY (In this place) <u>3 days</u>		d. STREET ADDRESS (If rural, give location) <u>2533 Bacon</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Terry</u> b. (Middle) <u>Everding</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>8-8-1949</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-11-1949</u>	9. AGE (In years last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>27</u>	IF UNDER 28 yrs. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Richmond Hts Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William Everding</u>	13b. MOTHER'S MAIDEN NAME <u>Rose Pie</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>William Everding</u> ADDRESS <u>2533 Bacon St</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>  <u>491X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>		
	ANTECEDENT CAUSES MORIBUND 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. <u>Conjunctive generalized muscular weakness</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Aug 5, 1949, to Aug 8, 1949, that I last saw the deceased alive on Aug 7, 1949, and that death occurred at 12:50 m., from the causes and on the date stated above.

23a. SIGNATURE <u>C. E. Williamson</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>6336 Clayton Road</u>	23c. DATE SIGNED <u>Aug 8, 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8-8-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	24d. LOCATION (City, town, or county) (State) <u>Red Bud Ill</u>
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DATE REC'D BY LOCAL REG. <u>8-10-49</u>	REGISTRAR'S SIGNATURE <u>Richard R. Shook, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service Inc</u> ADDRESS _____
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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.

Signed Ronald Dyahnske

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2917

P. O. Address Othman 10 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.