

FILED NOV 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33021**
Registrar's No. **1187**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 610 Kentucky St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Meth. Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) EMIL	b. (Middle)	c. (Last) DERC	4. DATE OF DEATH (Month) (Day) (Year) 10-28 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 8-16-1909	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Nursery	11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Felix Derc	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) None	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Frank Derc	ADDRESS 6408 Washington St.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 2-3 days 431X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Toxic MYOCARDITIS		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) BRONCHO-PNEUMONIA DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 **10/28 1949** to **10/28 1949**, that I last saw the deceased alive on **10/28 1949**, and that death occurred at **11:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE M. E. Grimes, M.D.	(Degree or title)	23b. ADDRESS St. Joseph Mo	23c. DATE SIGNED 10-31-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-31-49	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG Nov. 2, 1949	REGISTRAR'S SIGNATURE Y. B. Jenkins	382	25. FUNERAL DIRECTOR'S SIGNATURE John D. Duff	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 John E. Repp

Licensed Embalmer No. 3986

P. O. Address St Joseph, 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.