

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39211

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>9585</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5551 Cabanne Residence</u>				d. STREET ADDRESS (If rural, give location) <u>5551 Cabanne</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u>		b. (Middle) <u>Walter</u>		c. (Last) <u>Rich</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 4, 1949</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 20, 1875</u>		9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1st Natl Bk</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Joseph Rich</u>			13b. MOTHER'S MAIDEN NAME <u>Ella Louise Williams</u>			14. NAME OF HUSBAND OR WIFE <u>Mrs. Orah Rich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Orah Rich 5551 Cabanne</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteritis - Atherosclerotic</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Probably terminal coronary</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Old hypertensive cardiac</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Before 1947</u> <u>11 1947</u> <u>3 hours</u> <u>1947+</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>vascular renal (Arteriosclerosis)</u>				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) <u>ST. LOUIS</u>			
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? <u>4221</u>			
22. I hereby certify that I attended the deceased from <u>10-22-</u> , 19 <u>49</u> , to <u>11-4-49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>11-4-</u> , 19 <u>49</u> , and that death occurred at <u>4:30</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Donald Clark M.D.</u>				(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>864 Hamilton Blvd</u>	
23c. DATE SIGNED <u>11-5-49</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>11/6/49</u>		24c. NAME OF CEMETERY OR CREMATORIAL SOCIETY <u>Greenwood Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Nashville Ill</u>	
DATE REC'D BY LOCAL REG. <u>NOV 7 1949</u>		REGISTRAR'S SIGNATURE <u>J B Sarsten</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alexander & Sons 6175 DePaul</u>			

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 *J. E. McCulloh*

Licensed Embalmer No. 2460

P. O. Address 6175 Dellman

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.