

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14486

State File No. _____

BIRTH NO. 22586-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3668

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

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 town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Friffin Desloge Hospital</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>23 TOWN St. Louis</u>	
		d. STREET ADDRESS (If rural, give location) <u>2712 Allan, 4</u>	
3. NAME OF DECEASED a. (First) <u>James</u> b. (Middle) <u>Robert</u> c. (Last) <u>Dyer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4 20 50</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>	8. DATE OF BIRTH <u>4-20-50</u>
9. AGE (In years last birthday) <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>0</u>
13a. FATHER'S NAME <u>William Reid Dyer</u>		13b. MOTHER'S MAIDEN NAME <u>Genevieve Theresa Mikolka</u>	
14. NAME OF HUSBAND OR WIFE <u>—</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>—</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Genevieve Theresa Dyer</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.		18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Immature premature labor.</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Premature rupture of membranes at 20 weeks gestation.</u> DUE TO (c) <u>Unknown</u> 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"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR? <u>761.5</u>		22. I hereby certify that I attended the deceased from <u>4/20</u> , 19 <u>50</u> , to <u>4/20</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4/20</u> , 19 <u>50</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>Lawrence J. Sandin M.D.</u>		23b. ADDRESS <u>1325 So Grand Blvd, St. Louis 4, Mo</u>	
23c. DATE SIGNED <u>4/20/50</u>		24. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	
24a. DATE <u>4-22-50</u>		24b. NAME OF CEMETERY OR CREMATORY <u>Mount Hope St. Louis County Mo</u>	
24c. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Langhorne</u>	
25. DATE REC'D. BY LOCAL REG. <u>APR 21 1950</u>		25. REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Langhorne</u>		25. ADDRESS <u>2341</u>	

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 _____

Not Embalmed Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed *James J. Geller* _____

Licensed Embalmer No. *Funeral Director* _____

P. O. Address *2301 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.