

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 9 1950

State File No. **18739**
Registrar's No. **4701**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO. VE 2059	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5829 PERSHING AVE. 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION DEACONESS HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) LOUIS	b. (Middle) J.	c. (Last) VIZARD.	4. DATE OF DEATH (Month) (Day) (Year) May 27, 1950
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH March 21, 1880	9. AGE (In years last birthday) (Month) (Day) (Year) (Min.) 70
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman;	10b. KIND OF BUSINESS OR INDUSTRY Tobacco retail.	11. BIRTHPLACE (State or foreign country) Ontario, Canada 2	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Michael Vizard.	13b. MOTHER'S MAIDEN NAME Mary unknown	14. NAME OF HUSBAND OR WIFE Marie S. Vizard.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Theodore A. Eggmann; 5829 Pershing
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Caecum		
	ANTECEDENT CAUSES Morbid 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Small Bowel Obstruction	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 153X
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22. I hereby certify that I attended the deceased from **5-20, 1950**, to **5-27, 1950** that I last saw the deceased alive on **5-27, 1950**, and that death occurred at **12:30P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Christy M. D.	23b. ADDRESS 714 University Club Bldg	23c. DATE SIGNED 5-27-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 0	24b. DATE 5/30/1950	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAY 29 1950	REGISTRAR'S SIGNATURE J. O. Faseler	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons; 7233 Delmar Blvd.,
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4701

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 Arnold W. Schene

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.