.S. No. 300
EV. 10.48

FILED JUN 29 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21925

BIRTH NO. _____ REG. DIST. NO. 818 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5478

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 613 Shenandoah Av

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 2239
d. STREET ADDRESS (If rural, give location): 613 Shenandoah Av

3. NAME OF DECEASED (Type or Print)
a. (First): Michael
b. (Middle):
c. (Last): Preis

4. DATE OF DEATH (Month) (Day) (Year): June 22 1950

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept 23 1867
9. AGE (In years last birthday): 82 — 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): Retired
10b. KIND OF BUSINESS OR INDUSTRY: R.R.
11. BIRTHPLACE (State or foreign country): Germany 4
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Michael Preis
13b. MOTHER'S MAIDEN NAME: Barbara Wininger
14. NAME OF HUSBAND OR WIFE: Louisa (Deceased)

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: Lucy Baer — ADDRESS: 613 Shenandoah Av

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

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. P.O. Ca of Colon

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Ca of Colon Benign Prostatic Hypertrophy
20. AUTOPSY? YES ☐ NO ☐

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 153X

22. *I hereby certify that I attended the deceased from* _____, 1947, *to* June 2, 1950, *that I last saw the deceased alive on* 2/1, 1950, *and that death occurred at* 4:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title)
23b. ADDRESS: 634 No Grand ave
23c. DATE SIGNED: 6-23-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/26/50
24c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery
24d. LOCATION (City, town, or county) (State): St Louis Mo.

DATE REC'D BY LOCAL REG.: JUN 23 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Mordell Funeral Home — ADDRESS: 1926 Allen Av

(Licensed Embalmer's Statement on Reverse Side)

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 me

working under my personal supervision.

Student Embalmer No.....

Signed Dale A Graumann

Signed.....
Student Embalmer

Licensed Embalmer No. 4533

P. O. Address 1926 Allen

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.

K