

FILED JUL 21 1950

STANDARD CERTIFICATE OF DEATH

24750

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5876**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo 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 Gardenville	
c. LENGTH OF STAY (in this place) 3 mos.		d. STREET ADDRESS (If rural, give location) 4929 Seibert	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) c. (Last) Faveere			4. DATE OF DEATH (Month) (Day) (Year) July 6, 1950		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec 21, 1867	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Belgium		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME not known	13b. MOTHER'S MAIDEN NAME not known	14. NAME OF HUSBAND OR WIFE Addie Faveere
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give year of entry)	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME Louis J. Faveere	ADDRESS Rt. 1 House Springs Mo
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Amputation Rt leg		
	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 7-3-50	19b. MAJOR FINDINGS OF OPERATION gangrene rt foot	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., for 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 Drop
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22. I hereby certify that I attended the deceased from **2-12**, 19**49**, to **7-6**, 19**50** that I last saw the deceased alive on **7-6**, 19**50** and that death occurred at **10:00** m., from the causes and on the date stated above.

23a. SIGNATURE Victor P. Scherman	(Degree or title) MD	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 7-6-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 7/8/50	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) Affton, Mo.
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DATE REC'D. BY LOCAL REGISTRAR'S SIGNATURE J. B. Lasata	REGISTRAR'S SIGNATURE J. B. Lasata	25. FUNERAL DIRECTOR'S SIGNATURE Ziegenhein & Sons	ADDRESS 7027 Gravois
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Frank J. Quinn

Signed.....
Student Embalmer

Licensed Embalmer No. *2245*

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.