

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32164

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2133

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koch (rural)</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>72 days</u>		d. STREET ADDRESS (If rural, give location) <u>Rex Hotel</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u>	b. (Middle) <u>John</u>	c. (Last) <u>Delaney</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>September 7 1950</u>
---	-------------------------	--------------------------	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>7-18-84</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
--------------------	-------------------------------	--	---------------------------------	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
--	---	---	---

13a. FATHER'S NAME <u>Thomas Delaney</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Mueller</u>	14. NAME OF HUSBAND OR WIFE <u>Estelle Davison, div.</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>486-18-9601</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital Records, Robt. Koch Hosp.</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		INTERVAL BETWEEN ONSET AND DEATH <u>? 4 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic pulmonary tuberculosis</u>		
	ANTECEDENT CAUSES Morbidity 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. <u>Arteriosclerotic heart disease</u>		<u>? 7 years</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	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) (STATE) _____
--	--	---

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? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from 6-27-50, 1950, to 9-7-50, 1950, that I last saw the deceased alive on 9-7-50, 1950, and that death occurred at 1:30A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Ellis J. Spring</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Robert Koch Hospital</u>	23c. DATE SIGNED <u>9-7-50</u>
---	--	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>SEPT 9 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, Mo.</u>
---	------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>7-8-50</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas R. Kates 2906 Gravois Ave.</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 Thomas C. Rice

Licensed Embalmer No. 4347

P. O. Address 2986 Hawaii

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.