FILED NOV 17 1950

STANDARD CERTIFICATE OF DEATH

State File No. 38460

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9445

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): 5801 Willmore Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 2029

d. STREET ADDRESS (If rural, give location): 5801 Willmore Rd

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

4. DATE OF DEATH (Month) (Day) (Year): Nov 24 1950

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): V
8. DATE OF BIRTH: 2-21-1864
9. AGE (In years last birthday): 86 — 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): Stationery Engr.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Caseyville Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: George Englebright
13b. MOTHER'S MAIDEN NAME: Anna Stephens.
14. NAME OF HUSBAND OR WIFE

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 ADDRESS: Mabel Lammers 5801 Willmore Rd

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): Metrol etrusy fuming — INTERVAL BETWEEN ONSET AND DEATH: yes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Bronchial asthma — yes
DUE TO (c): old age

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 ☐ 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? 241X

22. *I hereby certify that I attended the deceased from* June, 1950, *to* Nov 24, 1950, *that I last saw the deceased alive on* Nov 3, 1950 *and that death occurred at* 8:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. S. Pyne M.D.
23b. ADDRESS: 27529 Chembee
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 11-4-50
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Collinsville Illinois

DATE REC'D BY LOCAL REG.: NOV 7 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Howard F. Rowland

Signed.....
Student Embalmer.

Licensed Embalmer No. 3114

P. O. Address St Louis 10 M

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.