

1874

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

FILED DEC 27 1950

STANDARD CERTIFICATE OF DEATH

State File No. **42248**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10687**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) a. STATE 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	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS	
d. FULL NAME OF HOSPITAL OR INSTITUTION Vosp-1		e. If rural, give location 1800 Olive St.	

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Horster c. (Last) Horster			4. DATE OF DEATH (Month) (Day) (Year) 11 13 50		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify)	
8. DATE OF BIRTH 04-18-84		9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Retired		Mo.	
12. CITIZEN OF WHAT COUNTRY?			13a. FATHER'S NAME		
			Retired		

13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Retired		Retired	
15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, or unknown) (If yes, state year of dated of service)		16. SOCIAL SECURITY NO.	
Retired		Retired	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	
J. O. Vayls		1300 Clark	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)	
				DUE TO (c)	
				Cerebral	
				Apoplexy	
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 <input checked="" type="checkbox"/> NO <input 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? 234X	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Joseph M. Lunn		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 12/7/50	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
Anatomical Board		NOV 15 1950		Anatomical Board	

DATE REC'D BY LOCAL REG. NOV 15 1950		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	
				ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.	

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.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.