

FILED JAN 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3269

BIRTH NO. 5659-51 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 62

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

| | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before ad. Mission). a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. Louis Richmond Hgh.</u> | | c. LENGTH OF STAY (In this place) | |
| c. CITY (If outside corporate limits, write RURAL and give township) <u>18</u> OR TOWN <u>RICHMOND HEIGHTS</u> | | d. STREET ADDRESS (If rural, give location) <u>1209 BELLEUE 4485</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. MARY'S Hos</u> | | | |

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|---|--|--|---|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>BARBARA</u> b. (Middle) <u>MARIE</u> c. (Last) <u>DROEGE</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 8 - 51</u> | | |
| 5. SEX <u>FE</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u> | |
| 8. DATE OF BIRTH <u>JAN-2-51</u> | | 9. AGE (In years last birthday) <u>6</u> | | IF UNDER 1 YEAR: Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Mo</u> | |
| 12. CITIZENSHIP OF WHAT COUNTRY? | | | | | |

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME <u>JOHN F. DROEGE</u> | | 13b. MOTHER'S MAIDEN NAME <u>RITA BRINDGES</u> | | 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 <u>John F. Droege</u> ADDRESS <u>1209 Belleue</u> | |

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|--|--|---|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH | |
| *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Circulatory failure</u> | | | <u>2 days</u> | |
| | | ANTECEDENT CAUSES | | | | |
| | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | |
| | | DUE TO (b) <u>Isolytic Stroke</u> | | | <u>2 days</u> | |
| | | DUE TO (c) <u>Peritonitis</u> | | | <u>5 days</u> | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>576X</u> | | | | |

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|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>Peritonitis, perforated caecum</u> | | 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) | |

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|--|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 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 Jan 3, 1951, to Jan 8, 1951, that I last saw the deceased alive on Jan 8, 1951 and that death occurred at 7:25 m., from the causes and on the date stated above.

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|--|--|----------------------------------|--|--------------------------------|--|
| 23a. SIGNATURE (Degree or title) <u>LeRoy Deshpus MD</u> | | 23b. ADDRESS <u>3784 Ivanhoe</u> | | 23c. DATE SIGNED <u>1-9-51</u> | |
|--|--|----------------------------------|--|--------------------------------|--|

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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>1-9-51</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u> | | 24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u> | |
|---|--|-------------------------|--|---|--|--|--|

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|--|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. <u>1/9/51</u> | | REGISTRAR'S SIGNATURE <u>Robert R. Donke MD</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Schauer</u> ADDRESS <u>3125 Lafayette</u> | |
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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..... *Not Embalmed.*

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: