

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25016**

FILED AUG 11 1952

BIRTH NO. 73		REG. DIST. NO. 179		PRIMARY REG. DIST. NO. 5669		Registrar's No. 29	
1. PLACE OF DEATH a. COUNTY Lincoln 0570				2. USUAL RESIDENCE (Where deceased lived, if last 12 months; residence before admission) a. STATE Missouri b. COUNTY Lincoln			
b. CITY (If outside corporate limits, write RURAL and give township) Rural Hawkpoint		c. LENGTH OF STAY (in this place) 2 mo		c. CITY (If outside corporate limits, write RURAL and give township) St Louis Mo. 2109		d. STREET ADDRESS (If rural, give location) 4014 Dwyden	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5 mi. S.E. of Hawkpoint Mo							
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) LOUIS c. (Last) SULZE			4. DATE OF DEATH (Month) (Day) (Year) August 3-52				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Feb 13 1890	
9. AGE (In years, Months, Days) 62 5 30		10a. USUAL OCCUPATION (Give kind of work including most of work in even if retired) Shipping Clerk for		10b. KIND OF BUSINESS OR INDUSTRY Sub + Co St Louis		11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Edward Sulze		13b. MOTHER'S MAIDEN NAME Bernice Murphy		14. NAME OF HUSBAND OR WIFE Dora Sulze	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 366-05-5065		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence McKinlay Troy Mo			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchitis - genic. Catarrhus (Ball Lung.) ANTECEDENT CAUSES Morbid 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.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 162X				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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 11			
22. I hereby certify that I attended the deceased from me , 19 52 , to Aug 9, 19 52 , that I last saw the deceased alive on Aug 3, 52 , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (In full name or title) D. G. Lebeck MD				23b. ADDRESS Troy, Mo		23c. DATE SIGNED Aug 8, 52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Reinterred		24b. DATE Aug 6 52		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo	
DATE REC'D BY LOCAL REG. 8-9-52		REGISTRAR'S SIGNATURE Emma R. Riddle		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wayne M & Coy Troy Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 24 1958

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 Wayne M. Coy
Licensed Embalmer No. 3586

P. O. Address Jay 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.