

26163

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 22 1952

Registrar's No. 6762

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No.											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri				b. COUNTY St. Charles									
b. CITY (If outside corporate limits, write BURAL and give township) OR TOWN St. Louis				c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write BURAL and give township) OR TOWN St. Charles		0923									
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital				d. STREET ADDRESS (If rural, give location) 331 Jackson				/									
3. NAME OF DECEASED (Type or Print)			a. (First) Theodore			b. (Middle)			c. (Last) Neindick			4. DATE OF DEATH (Month) (Day) (Year) July 10, 1952					
5. SEX M Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sept. 5, 1885		9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours		IF UNDER 1 YEAR Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY Own business				11. BIRTHPLACE (City and State or Foreign Country) St. Charles Co., Mo.				12. CITIZEN OF WHAT COUNTRY?					
13a. FATHER'S NAME George Neindick				13b. MOTHER'S MAIDEN NAME Sophia Walkenbrock				14. NAME OF HUSBAND OR WIFE Minnie									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO. 487-38-1035				17. INFORMANT'S SIGNATURE OR NAME Minnie Neindick				ADDRESS St. Charles, Mo.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION										INTERVAL BETWEEN ONSET AND DEATH 5 Months					
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myelogenous Leucemia															
		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 July 2-5-52		19b. MAJOR FINDINGS OF OPERATION Removal of Spleen (8 1/2 lbs)										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 2041													
22. I hereby certify that I attended the deceased from July 12, 1952 , to July 10, 1952 , that I last saw the deceased alive on July 10, 1952 , and that death occurred at 8:55 p. m. , from the causes and on the date stated above.																	
23a. SIGNATURE (Degree or title) X. J. Sauter M.D.						23b. ADDRESS St. Ann's Hospital						23c. DATE SIGNED July 11-52					
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-11-52		24c. NAME OF CEMETERY OR CREMATORY				24d. LOCATION (City, town, or county) (State) St. Charles, Mo.									
DATE REC'D BY LOCAL REG. JUL 11 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe				ADDRESS 4700 Washington Blvd							
DATE REC'D BY LOCAL REG. JUL 11 1952		m 823 (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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

John H. Henneke

Licensed Embalmer No. *71940*

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.