

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7841**
1788
Registrar's No.

FILED MAR 11 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) 23 162 Sidney	

3. NAME OF DECEASED (Type or Print) VALENTINE PFEIFER			4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 9, 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb. 22, 1877	9. AGE (In years last birthday) 75	10. CITIZEN OF WHAT COUNTRY? Austria
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tinsmith & coppersmith		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Austria	

13a. FATHER'S NAME John	13b. MOTHER'S MAIDEN NAME Mary	14. NAME OF HUSBAND OR WIFE --
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 482-03-1608	17. INFORMANT'S SIGNATURE OR NAME Hospital Record

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Aspiration pneumonia INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Bailey's Disease		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic obstructive heart disease Acute hepatitis	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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? 491X

22. I hereby certify that I attended the deceased from **1-21-53**, 19___, to **2-9-53**, 19___, that I last saw the deceased alive on **2-9-53**, 19___, and that death occurred at **8:50Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Albert E. Stock M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 2-10-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB 17 53	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
DATE REC'D BY LOCAL REG. FEB 16 1953	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen-Kelly 4386 Lindell	

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
at College of Mortuary Science Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed Ralph W. Henson

Licensed Embalmer No. 3791

P. O. Address St. Louis, 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.