

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2709

FILED FEB 2 1954

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1003 State File No. Registrar's No. 0782

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda Hospital				• STREET ADDRESS (If rural, give location) 4167 Blaine Ave. 2189			
3. NAME OF DECEASED (Type or Print) a. (First) Oland		b. (Middle) F.		c. (Last) Dell		4. DATE OF DEATH (Month) (Day) (Year) Jan. 24, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH March 1, 1910		9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chaufeur		10b. KIND OF BUSINESS OR INDUSTRY Concrete Inc.		11. BIRTHPLACE (City and State or Foreign Country) Waynesville, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Robert H. Dell		13b. MOTHER'S MAIDEN NAME Carrie Laughlin		14. NAME OF HUSBAND OR WIFE Charlotte			
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. 492-10-4737		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. P. Webb, 4167a Blaine Ave.			
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) Advanced leukemia of liver ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Esophageal varicosis with hemorrhage DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
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. HOW DID INJURY OCCUR? _____ 5810	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 1/20 , 1954, to 1/24 , 1954, that I last saw the deceased alive on 1/23 , 1954, and that death occurred at 2:05 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Hereward Parker M.D.		23b. ADDRESS 4668 Maryland		23c. DATE SIGNED 1/25/54			
24a. BURIAL-CREMA-TION-REMOVAL (Specify) Removal		24b. DATE: 1-25-54		24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery		24d. LOCATION (City, town, or county) (State) Waynesville, Mo.	
DATE REC'D BY LOCAL REG. JAN 25 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			

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.....
Signature of Student Embalmer

Signed..... *Paul A. Wachter*

Licensed Embalmer No. *478*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.