

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6647**
Registrar's No. **1703**

BIRTH NO. FILED **MAR 8 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY 2239			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 73 2113 OREGON			
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE		b. (Middle) ERNEST		c. (Last) PADE	
4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 21, 1954		5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH Nov. 7 1881		9. AGE (In years last birthday) 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (City and State or Foreign Country) KENTUCKY	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME E. PADE		13b. MOTHER'S MAIDEN NAME ELIZA TRAVIS	
14. NAME OF HUSBAND OR WIFE VERA PADE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME VERA PADE		18. ADDRESS 2113 OREGON		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral Hemorrhage	
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive Card. Vasc. Disease	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443X	
22. I hereby certify that I attended the deceased from 2-18-54 , 19___, to 2-21-54 , 19___, that I last saw the deceased alive on 2-21-54 , 19___, and that death occurred at 2:10A m., from the causes and on the date stated above.					
23a. SIGNATURE Clair R. Arnold M.D.		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 2-22-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE FEB 24 1954		24c. NAME OF CEMETERY OR CREMATORY LAUREL HILL	
24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo		DATE REC'D BY LOCAL REG. FEB 23 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis		ADDRESS 2906 Travis		(Licensed Embalmer's Statement on Reverse Side)	

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 *James C. Hill*.....

Licensed Embalmer No. *434*.....

P. O. Address *2906 St.*.....

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.