No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 6 1954

State File No. 10028

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2784

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (In this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Incarnate Word Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY St Louis 1001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Johns no
d. STREET ADDRESS (If rural, give location): 3522 Brown

3. NAME OF DECEASED (Type or Print)
a. (First): Fred
b. (Middle): Ford
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): March 26 1954

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 12 1873
9. AGE (In years last birthday): 80 — 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): Mechanic.
10b. KIND OF BUSINESS OR INDUSTRY: Auto
11. BIRTHPLACE (State or foreign country): Springfield Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Thomas Ford
13b. MOTHER'S MAIDEN NAME: Catherine Mulvihill
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Margaret Gundaker 3522 Brown

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bilateral Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

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. Coronary Occlusion — 3 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

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): 490X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 2-10-, 1954, *to* 3-26-, 1954, *that I last saw the deceased alive on* 3-26, 1954, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Herman J. Kloeker (Degree or title) MD
23b. ADDRESS: 96 S. Lackland Rd.
23c. DATE SIGNED: 3-26-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Mar 29 '54
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
24d. LOCATION (City, town, or county) (State): St Louis Mo

DATE REC'D BY LOCAL REG.: MAR 27 1954
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ortmann F Home 9222 Lackland
M&B
(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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Al C Ostrander

Signed.....
Student Embalmer

Licensed Embalmer No. 3478

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.