

FILED MAY 6 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14023**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3911**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>7427a Pennsylvania</b>		e. STREET ADDRESS (If rural, give location) <b>7427a Pennsylvania 2019</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Joseph</b> b. (Middle) c. (Last) <b>Rodriguez</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 28, 1954.</b>
--	---

5. SEX <b>male</b>	6. COLOR (OR RACE) <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Jan. 23, 1892.</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days	IF OVER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Spain</b>		12. CITIZEN OF WHAT COUNTRY? <b>A</b>

13a. FATHER'S NAME <b>Narcelino Rodriguez</b>	13b. MOTHER'S MAIDEN NAME <b>Josephine Gotirrez</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Rodriguez</b>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Mary Rodriguez</b>	ADDRESS <b>7427A Pennsylvania</b>
--	-------------------------	---	-----------------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>		<b>1 day</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) <b>Chronic Bronchitis</b>		<b>? 0</b> <b>2 yrs</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) <b>4201</b>
--	--	--

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?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **Jan 1953** to **Apr 28, 1954**, that I last saw the deceased alive on **Apr 25, 1954**, and that death occurred at **7:20 m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>George A. O'Sullivan, M.D.</b>	(Degree or title) <b>D</b>	23b. ADDRESS <b>4221 W. Schurmer</b>	23c. DATE SIGNED <b>4-30-54</b>
--	----------------------------	--------------------------------------	---------------------------------

24a. BURIAL, CREMATION (Specify) <b>burial</b>	24b. DATE <b>May 1, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
--	------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>APR 30 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. P. Fendler Jr.</b>	ADDRESS <b>Funeral Home. 7128 Michigan</b>
---	--	---	--

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

*[Handwritten signature]*

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 *[Handwritten Signature]*

Licensed Embalmer No. *43*

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