

FILED AUG 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25086**
6287

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO.	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Blue Mound	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		f. STREET ADDRESS (If rural, give location) 8120 g	

3. NAME OF DECEASED (Type or Print) a. (First) Roy	b. (Middle) V.	c. (Last) Pistorius	4. DATE OF DEATH (Month) (Day) (Year) July 9 1954
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug 1, 1897
9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	11. BIRTHPLACE (City and State, or Foreign Country) Blue Mound, Ill.
10b. KIND OF BUSINESS OR INDUSTRY own farm		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Samuel Pistorius	13b. MOTHER'S MAIDEN NAME Elizabeth Hobusch	14. NAME OF HUSBAND OR WIFE unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. WW#1	17. INFORMANT'S SIGNATURE OR NAME Ater Funeral Home ADDRESS Blue Mound, Ill

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* (a) Brain Tumor		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	ANTECEDENT CAUSES 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.		

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. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 193x

22. I hereby certify that I attended the deceased from June 30, 1954, to July 9, 1954, that I last saw the deceased alive on July 9, 1954, and that death occurred at 1:35 Am., from the causes and on the date stated above.

23a. SIGNATURE FR Bradley (Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 7/9/54
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 7-10-54	24c. NAME OF CEMETERY OR CREMATORY
		24d. LOCATION (City, town, or county) (State) Blue Mound, Ill.

DATE REC'D BY LOCAL REG. JUL 12 1954	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Ater F.H., Blue Mound, Ill. ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

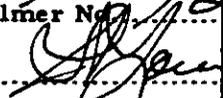
STATEMENT BY LICENSED EMBALMER

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.....


Licensed Embalmer No. 40.....

P. O. 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.