

FILED SEP 2 1954

STANDARD CERTIFICATE OF DEATH

State File No. 28786
7539

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 Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis Mo		c. LENGTH OF STAY (In this place) 30 years	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4340 Linton		e. STREET ADDRESS (If rural, give location) 4340 Linton - 2099	
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) c. (Last) Dreier		4. DATE OF DEATH (Month) (Day) (Year) 8-13-54	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-22-1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 79
11. BIRTHPLACE (City and State or Foreign Country) Austria		12. CITIZEN OF WHAT COUNTRY? Austria	
13a. FATHER'S NAME John Dreier		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
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. 489-03-5084	17. INFORMANT'S SIGNATURE OR NAME Hilda Rogers-4340 Linton
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 INTERVAL BETWEEN ONSET AND DEATH 4 days	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		ANTECEDENT CAUSES DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cirrhosis Liver			
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) 332X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Aug 1, 1954, to Aug 13, 1954, that I last saw the deceased alive on Aug 12, 1954, and that death occurred at 10 P. m., from the causes and on the date stated above.			
23a. SIGNATURE A. H. Presener M.D.		23b. ADDRESS 6000 W. Florissant	
23c. DATE SIGNED 8-14-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-17-1954	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. AUG 16 1954		REGISTRAR'S SIGNATURE J. Earl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Edw. Koch + Son - 3516 N. 14th		ADDRESS	

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 *Bill C. Branson*.....

Licensed Embalmer No. *476*

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.