

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

FILED MAR 8 1955

State File No. **6773**

|                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                       |                                                                                                                    |                                                                            |                                                                                                                        |                                                        |                                                                                  |                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------|
| BIRTH NO. _____                                                                                                                                                                                                                                  |  | REG. DIST. NO. <b>317</b>                                                                              |                                                                       | PRIMARY REG. DIST. NO. <b>5475</b>                                                                                 |                                                                            | Registrar's No. <b>446</b>                                                                                             |                                                        |                                                                                  |                                         |
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b> <span style="float:right">2</span>                                                                                                                                                               |  |                                                                                                        |                                                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> |                                                                            |                                                                                                                        |                                                        | b. COUNTY <b>St. Louis</b>                                                       |                                         |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Richmond Heights</b>                                                                                                                                             |  |                                                                                                        | c. LENGTH OF STAY (in this place) <b>DOA</b>                          | c. CITY OR TOWN <b>Afton</b>                                                                                       |                                                                            | 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: <b>St. Mary's Hospital</b>                                                                                                                                                                              |  |                                                                                                        |                                                                       | e. STREET ADDRESS (If rural, give location) <b>R.R.14 Box 1005</b>                                                 |                                                                            |                                                                                                                        |                                                        |                                                                                  |                                         |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>William</b>                                                                                                                                                                                 |  |                                                                                                        | b. (Middle) <b>M.</b>                                                 |                                                                                                                    | c. (Last) <b>Engel</b>                                                     |                                                                                                                        | 4. DATE OF DEATH (Month) (Day) (Year) <b>2-19-1955</b> |                                                                                  |                                         |
| 5. SEX <b>Male</b> <input type="radio"/>                                                                                                                                                                                                         |  | 6. COLOR OR RACE <b>White</b>                                                                          | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> |                                                                                                                    | 8. DATE OF BIRTH <b>5-2-1902</b>                                           |                                                                                                                        | 9. AGE (In years last birthday) <b>52</b>              | IF UNDER 1 YEAR Months _____ Days _____                                          | IF UNDER 10 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - self employ drainage</b>                                                                                                                |  |                                                                                                        | 10b. KIND OF BUSINESS OR INDUSTRY _____                               |                                                                                                                    | 11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>         |                                                                                                                        | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>             |                                                                                  |                                         |
| 13a. FATHER'S NAME <b>Edward Engel</b>                                                                                                                                                                                                           |  |                                                                                                        | 13b. MOTHER'S MAIDEN NAME <b>Margaret Doering</b>                     |                                                                                                                    |                                                                            | 14. NAME OF HUSBAND OR WIFE <b>Helen Engel</b>                                                                         |                                                        |                                                                                  |                                         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>                                                                                                                               |  | 16. SOCIAL SECURITY NO. <b>498-26-8379</b>                                                             |                                                                       | 17. INFORMANT'S SIGNATURE OR NAME <b>Helen Engel</b>                                                               |                                                                            | ADDRESS <b>Afton Mo</b>                                                                                                |                                                        |                                                                                  |                                         |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                    |  |                                                                                                        |                                                                       | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial infarction</b>                                |                                                                            |                                                                                                                        |                                                        | INTERVAL BETWEEN ONSET AND DEATH                                                 |                                         |
|                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                       | ANTECEDENT CAUSES<br>DUE TO (b) <b>Arteriosclerosis</b>                                                            |                                                                            |                                                                                                                        |                                                        |                                                                                  |                                         |
|                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                       | DUE TO (c) <b>Deafness</b>                                                                                         |                                                                            |                                                                                                                        |                                                        |                                                                                  |                                         |
| II. OTHER SIGNIFICANT CONDITIONS<br>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) <b>X</b>                                                                                                                                                                                                |  | 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) _____                                                                                                                                                                                            |  | 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 _____, 1950, to <b>2/19</b> , 1955, that I last saw the deceased alive on <b>2/19</b> , 1955, and that death occurred at <b>7:30 P.m.</b> , from the causes and on the date stated above. |  |                                                                                                        |                                                                       |                                                                                                                    |                                                                            |                                                                                                                        |                                                        |                                                                                  |                                         |
| 23a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD</b>                                                                                                                                                                                    |  |                                                                                                        |                                                                       | 23b. ADDRESS <b>4161 Lundeal</b>                                                                                   |                                                                            |                                                                                                                        | 23c. DATE SIGNED <b>2/21/55</b>                        |                                                                                  |                                         |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                          |  | 24b. DATE <b>2-23-1955</b>                                                                             | 24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Parl</b>          |                                                                                                                    | 24d. LOCATION (City, town, or county) (State) <b>10160 Gravois Road Mo</b> |                                                                                                                        |                                                        |                                                                                  |                                         |
| DATE REC'D BY LOCAL REG. <b>2/21/55</b>                                                                                                                                                                                                          |  | REGISTRAR'S SIGNATURE <b>[Signature]</b>                                                               |                                                                       | FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>                                                                    |                                                                            | ADDRESS <b>6409 Gravois Ave</b>                                                                                        |                                                        |                                                                                  |                                         |

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

(Licensed Embalmers' Statement on Reverse Side)

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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, ~~by~~ ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Elmo R. Gadwell*.....

Licensed Embalmer, No. *402*

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.