

XC-None
Reg. 9566

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24260

State File No.

BIRTH NO. SL-6385 FILED AUG. 2-1955 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6064

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY ST. CLAIR			
b. CITY (If outside corporate limits, write RURAL and give town) 915 N. Grand, St. Louis, Mo.		c. LENGTH OF STAY (in this place) 6 days		c. CITY OR TOWN ST. LIBORY	
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hosp.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) a. (First) JOHN		b. (Middle) H.		c. (Last) RECKER	
4. DATE OF DEATH (Month) (Day) (Year) 7-11-55		5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, NEVER MARRIED		8. DATE OF BIRTH 1-24-95		9. AGE (In years last birthday) 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Harness Maker		10b. KIND OF BUSINESS OR INDUSTRY Harness Manufacturing		11. BIRTHPLACE (City and State or Foreign Country) ST. LIBORY, ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William Recker		13b. MOTHER'S MAIDEN NAME Mary Stumpf	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. 33318 8650	
17. INFORMANT'S SIGNATURE OR NAME VA Hosp. Records, 915 N. Grand, St. Louis, Mo.		17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	
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.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Constrictive Pericarditis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		DUE TO (b) Carcinoma of Esophagus			
		DUE TO (c)			
11. 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 150X	
22. I hereby certify that I ^{VA} attended the deceased from 7-5-55 , 19 55 , to 7-11-55 , 19 55 , and that death occurred at 11:25a m., from the causes and on the date stated above.					
23a. SIGNATURE T. P. Taylor		23b. ADDRESS Carroll 7300 Clark		23c. DATE SIGNED 7.13.55	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED		24b. DATE 7-15-55		24c. NAME OF CEMETERY OR CREMATORY National	
24d. LOCATION (City, town, or county) (State) Jefferson Bls		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Edward Smith 5611 Grand			

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Bon E. Hoffmann*

Licensed Embalmer No. *43*

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.