

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38096

State File No.

XC- Unknown
Reg. 12135 SI-7805

BIRTH NO. FILED NOV 18 1955 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9745

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 MISSOURI b. CITY OR TOWN ST. LOUIS c. CITY OR TOWN ST. LOUIS d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 915 N. Grand, St. Louis, Mo.		c. LENGTH OF STAY (in this place) 2 days		e. STREET ADDRESS (If rural, give location) 21 819 N. LEFFINGWELL 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hosp.					
3. NAME OF DECEASED (Type or Print) WADE		a. (First)		b. (Middle)	
4. DATE OF DEATH 11-4-55		c. (Last) CHASE		5. DATE (Month) (Day) (Year)	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH 6-6-93		9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER		10b. KIND OF BUSINESS OR INDUSTRY FISHER BODY CO.		11. BIRTHPLACE (City and State or Foreign Country) / CHOTARD, MISSISSIPPI	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME GEORGE CHASE		13b. MOTHER'S MAIDEN NAME REBECCA (Unknown)	
14. NAME OF HUSBAND OR WIFE THELMA CHASE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 489 09 1796	
17. INFORMANT'S SIGNATURE OR NAME VA HOSP. 915 N. Grand, St. Louis, Mo.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHOPNEUMONIA, LEFT LOWER LOBE INTERVAL BETWEEN ONSET AND DEATH 5 days *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Old Myocardial Infarction Conditions contributing to the death but not related to the disease or condition causing death. Gastric Ulcer Unknown		19. NAME OF HUSBAND OR WIFE THELMA CHASE	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 491X		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	
22. I hereby certify that I attended the deceased from 11-2-55, 19__, to 11-4-55, 19__, that I am the deceased's physician, and that death occurred at 9:15 a. m., from the causes and on the date stated above.					
23. SIGNATURE Hy. Westphaelinger M.D.		23b. ADDRESS VAH, 915 N. Grand, St. Louis, Mo.		23c. DATE SIGNED 11-4-55	
24. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 11-10-55		24c. NAME OF CEMETERY OR CREMATORY National	
24d. LOCATION (City, town, or county) (State) Jefferson Barracks MO.		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith		ADDRESS Wellis Funeral Home 2820 Stoddard	
DATE REC'D BY LOCAL REG. NOV 8 1955		REGISTRAR'S SIGNATURE 2219 (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 *Fulton E. Culkin*.....

Licensed Embalmer No. *419*.....

P. O. Address *St. Paul*.....

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.