

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24909

State File No.

FILED JUL 20 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6203**

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. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 3619 Shenandoah		STREET ADDRESS (If rural, give location) 17 3619 Shenandoah 2179	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) A. c. (Last) Daniel		4. DATE OF DEATH (Month) (Day) (Year) July 1, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3-20; 1881
9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Service	10b. KIND OF BUSINESS OR INDUSTRY Upholstery Dept.	11. BIRTHPLACE (City and State or Foreign Country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Don't know	
13b. MOTHER'S MAIDEN NAME Don't know		14. NAME OF HUSBAND OR WIFE Dec. Rosie Hoffman Daniel	
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. Don't Know	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Josie Hettel		ADDRESS 3619 Shenandoah	
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) myocardial failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary atherosclerosis DUE TO (c) arteriosclerosis 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 4221	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	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 5/54 , 19 54 , to 6/56 , 19 56 , that I last saw the deceased alive on 6/09 , 19 56 and that death occurred at 5 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Thaddeus G. Schubert M.D.		23b. ADDRESS 39034 Paul Ave	
23c. DATE SIGNED 7/2/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 3, 1956	24c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery	24d. LOCATION (City, town, or county) (State) Highland, Illinois
DATE REC'D BY LOCAL REG. JUL 2 1956	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Weick Bros 2201 S. Grand Blvd	

Dr. F. R. Seibert

2203 Lawrence Ave

Pr I-7737

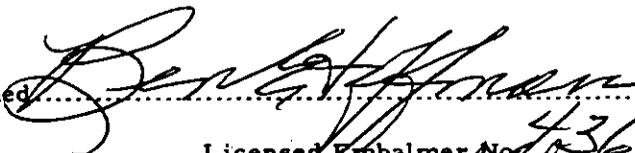
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

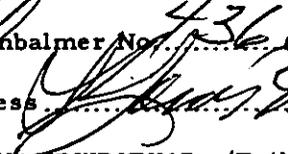
by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 436.....

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.