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Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part 1 must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 35388

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9791

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSPITAL #1. — Length of stay in 1b: 22 D

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2345 Rutger — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CHARLES — Middle — Last CONRADS
4. DATE OF DEATH: Month OCT. Day 25 Year 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 13-1868
9. AGE (In years last birthday): 87 — 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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Sheet Metal
11. BIRTHPLACE (City and state or country): Washington,Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Julius Conrads
14. MOTHER'S MAIDEN NAME: Emilia (unk)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Charles T.Conrads — Address: 4204 Ellenwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOVASCULAR ACCIDENT
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 422.1
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from 10/20/56, to 10/25/56 and last saw her/him alive on 10/25/56
Death occurred at 7:35 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: N Kabalin, MD (Degree or title)
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 10/26/56.

23a. BURIAL, CREMATION, REMOVAL (Specify): Creamtion
23b. DATE: 10-26-1956
23c. NAME OF CEMETERY OR CREMATORY: Missouri Crematory
23d. LOCATION (City, town, or county) (State): St.Louis,Mo.

24. FUNERAL DIRECTOR: E.J. Schnur — ADDRESS: 3125 Lafayette
25. DATE REC'D. BY LOCAL REG.: OCT 26 1956
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

(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 em

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

working under my personal supervision.. Not Embalmed

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.