

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30116

FILED SEP 4 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7928**

STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 4020 FAIRVIEW		d. STREET ADDRESS 4020 FAIRVIEW	

3. NAME OF DECEASED (Type or print) First JOSEPH Middle Last ULRICH			4. DATE OF DEATH Month AUG Day 23 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 1 1876	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE REPAIRMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) BOHEMIA	12. CITIZEN OF WHAT COUNTRY? U-S-A
13. FATHER'S NAME ANTHONY ULRICH			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT FRANK A ULRICH 4726 VIENNA	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Primary Pancreas DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 Mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
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 July 1957 to Aug 23 1957 and last saw him alive on Aug 23, 1957 Death occurred at 12:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE John W. Daake M.D. (Degree of title)	22b. ADDRESS 3606 Gravois	22c. DATE SIGNED 8-23-57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUG 26 1957	23c. NAME OF CEMETERY OR CREMATORY ST PETER + PAUL CEM	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
24. FUNERAL DIRECTOR Thomas Kutz ADDRESS 2906 Gravois	25. DATE RECD. BY LOCAL REG. AUG 24 '57	26. REGISTRAR'S SIGNATURE Carl Smith - MD <i>hem</i>	

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

330-5

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James C. Hill*

Licensed Embalmer No. *4*.....

P. O. Address *2906*.....

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.