FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38426
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2383

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis Co. Hosp. — Length of stay in 1b D.O.A.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Ferguson 4109 0 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) #10 Kings Court — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First WILLIAM Middle T. Last ANTHONY
4. DATE OF DEATH Month Sep. Day 25 Year 1957
5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 2
8. DATE OF BIRTH Jan. 14, 1883
9. AGE (In years last birthday) 74 — 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) Clerk-Con P. Curran
10b. KIND OF BUSINESS OR INDUSTRY Printing Co.
11. BIRTHPLACE (City and state or country) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Anthony
14. MOTHER'S MAIDEN NAME Margaret Moroney
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 493-01-4611
17. INFORMANT Margaret Chapman Address #10 Kings Court

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) Unknown natural causes — INTERVAL BETWEEN ONSET AND DEATH unk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____ 7954
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 ☐ NO ☒ 2
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 ____, to ____ and last saw her/him alive on ____
Death occurred at 6:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Herbert R. Domke 8 — Herbert R. Domke, M.D., Local Registrar
22b. ADDRESS 651 S. Brentwood Blvd.
22c. DATE SIGNED 10/4/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Sep. 28, 1957
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG. 9-26-57
26. REGISTRAR'S SIGNATURE Herbert R Domke MD Dec.

Health, & Welfare Public Service
S. 300 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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..

Student.....
Signature of Student Embalmer

Signed Richard W. Stove

Licensed Embalmer No. 40

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.