

Health & Welfare  
Public Health Service

S. 300  
v. 156

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

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

385336

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2430

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Imperial</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph Hosp.</u>			Length of stay in lb <u>D.O.A</u>		d. STREET ADDRESS (If outside, give location) <u>Rt 1 Box 196</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Adolph</u> <u>Geist</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5 1891</u>		9. AGE (In years last birthday) <u>66</u> IF UNDER 1 YEAR Months <u>5</u> Days <u>24</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Work</u>		11. BIRTHPLACE (City and state or country) <u>St Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Adoph Geist Sr</u>				14. MOTHER'S MAIDEN NAME <u>Julia Johns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-20-4884</u>		17. INFORMANT <u>Mrs Minnie Geist</u> Address <u>Rt 1 Box 196 Imperial Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown natural causes</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <u>7954</u>							INTERVAL BETWEEN ONSET AND DEATH <u>death</u>
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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Herbert R. Domke, MD.</u> (Doctor or title)				22b. ADDRESS <u>651 S. Brentwood, Clayton, Mo.</u>		22c. DATE SIGNED <u>10/4/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 2 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Lemay, Mo.</u>		
24. FUNERAL DIRECTOR <u>Fey Funeral Home, Mehlville Mo.</u>			ADDRESS		25. DATE REC. BY LOCAL REG. <u>10-1-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Domke, MD.</u>	

(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 *James Binkley* .....

Licensed Embalmer No. *365*  
P. O. Address *St Louis*

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.