

Dr. Health,
& Welfare
S. Public
Hth Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 22 1957

42009
STATE FILE NUMBER
10388

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 10388

300
-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY | | a. STATE <u>MO</u> COUNTY <u>St Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> | | c. CITY OR TOWN <u>Overland</u> <u>423X</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo Bapt Hosp</u> | | Length of stay in lb <u>3 wks</u> | d. STREET ADDRESS (If outside, give location) <u>27 9612 Tennyson</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN GIRARD</u> | | | 4. DATE OF DEATH Month Day Year <u>Nov 3 1957</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 13 1883</u> |
| 9. AGE (In years last birthday) <u>74</u> | 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) <u>Painter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Residence</u> | 11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13a. FATHER'S NAME <u>Louis Girard</u> | | 13b. MOTHER'S MAIDEN NAME <u>Catherine Hester</u> | 14. NAME OF HUSBAND OR WIFE |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>Yes WWI</u> | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address <u>Mary Girard Overland 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>Intestinal hemorrhages - etiology undetermined</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 Days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | <u>578x</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not the terminal disease condition given in PART I (a) <u>Hypertension, Senility, old CVA</u> | | | 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 <u>10-19-57</u> to <u>11-3-57</u> and last saw him alive on <u>11-3-57</u> Death occurred at <u>10</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>A. J. Steiner</u> (Degree or title) <u>A. J. Steiner MD</u> | | 22b. ADDRESS <u>3903 Olive</u> <u>3903 Olive Str.</u> | 22c. DATE SIGNED <u>11/4/57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Nov 6 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland</u> <u>Overland Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>NOV 4 '57</u> | 26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>msB</u> |

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 *Al C. Ortman*

Licensed Embalmer No. *3478*

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.