

STANDARD CERTIFICATE OF DEATH

475334
STATE FILE NUMBER
12724
Registration No.

FILED FEB 4 1958

Registration District No. 318 Primary Registration District No. 1003

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>ST. LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FERGUSON</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET ADM. HOSPITAL</u>		Length of stay in lb <u>DOA</u>	d. STREET ADDRESS (If outside, give location) <u>723 DARST ROAD.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H</u> Last <u>FRENCH</u>			4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>57</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-95</u>	9. AGE (In years last birthday) <u>62</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>MEDICAL ILLUSTRATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</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>ALBERT O FRENCH</u>		13b. MOTHER'S MAIDEN NAME <u>ANNABELLE HOUSTON</u>		14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give dates of service) <u>YES WW 1</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT Address <u>VA HOSP RECORDS 915 N GRAND ST LOUIS 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>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>BRONCHO PNEUMONIA</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>RHEUMATOID ARTHRITIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 MIN.</u> <u>5 DAYS</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.) <u>* * *</u>			
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.) <u>* * *</u>		20f. CITY, TOWN, OR LOCATION <u>* * *</u>		COUNTY <u>* * *</u>	STATE <u>* * *</u>
21. I attended the deceased from <u>12-16-57</u> to <u>12-31-57</u> and last saw <u>him</u> live on <u>12-31-57</u> Death occurred at <u>12:45 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Herbert Luke M. D.</u>			22b. ADDRESS <u>845 LONGACRE, U. CITY, MO.</u>		22c. DATE SIGNED <u>12-31-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-3-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>	
24. FUNERAL DIRECTOR <u>C. R. Lupton & Sons 7233 Delmar</u>			25. DATE RECD. BY LOCAL REG. <u>JAN 2 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M. D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

PROV. SEC.

EXHIBIT

RECORD

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ASSN. NO. 1234

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STATE OF MISSOURI

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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 *Arnold W. Schoene*

12-12-23

12-12-23

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo.

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.