

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002650
STATE FILE NUMBER

FILED FEB 11 1959

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 37

300
1-57

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

1. PLACE OF DEATH a. COUNTY St. Francois			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Webster Groves 4007		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #4		Length of stay in 1b 6Y;6M;4das.	d. STREET ADDRESS (If outside, give location) 521 Greeley		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FREDERICK Last SUENDER			4. DATE OF DEATH Month February Day 2 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1875		9. AGE (In years last birthday) 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Statistical analyst for oil companies.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Coblentz, Germany 4	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Frederick Suender		13b. MOTHER'S MAIDEN NAME Mary Kessler		14. NAME OF HUSBAND OR WIFE Mabel J. Cobb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, State Hospital No. 4, Farmington, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from parotid gland - - - - -					INTERVAL BETWEEN ONSET AND DEATH Abt. 12 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of parotid gland - - - - -					Abt. 1 year.
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Psychosis with cerebral arteriosclerosis.					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 <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 28, 1952 to Feb. 2, 1959 and last saw ^{him} alive on Feb. 2, 1959 Death occurred at 1:10 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>John A. Brennan, M.D.</i> (Degree or title)			22b. ADDRESS State Hospital No. 4 Farmington, Missouri		22c. DATE SIGNED 2-2-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Feb. 3, 1959	23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Parker-Aldrich Funeral Home, Webster Groves, Mo.			25. DATE RECD. BY LOCAL REG. 2/3/59		26. REGISTRAR'S SIGNATURE <i>Ethel Rudloff</i>

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 No embalming, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Wester Grove

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.