

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016030

STATE FILE NUMBER

APR 27 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1057

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN BELLEFONTAINE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION COUNTY		Length of stay in 1b 2 mos 17 days	d. STREET ADDRESS (If outside, give location) OLIVE ST. Ro.
3. NAME OF DECEASED (Type or print) First RAYMOND Middle ANDREAS Last ANDREAS			4. DATE OF DEATH Month 4 Day 17 Year 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL	11. BIRTHPLACE (City and state or country) ST. LOUIS MO.
13a. FATHER'S NAME CHAS. ANDREAS		13b. MOTHER'S MAIDEN NAME ANNIE ENGELKE	14. NAME OF HUSBAND OR WIFE _____
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. _____	17. INFORMANT LOUIS A. ANDREAS Address CHESTERFIELD, 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) Emaciation and Cachexia			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) Carcinoma of Common bile duct			
DUE TO (c) metastases to liver and ? brain			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Broncho-pneumonia			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ o.m. _____ p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1-30-1959 to 4-17-1959 and last saw him alive on 4-17-1959 Death occurred at 10:39 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John E. Oakley, M.D.		22b. ADDRESS 601 S. BRENTWOOD BLVD.	22c. DATE SIGNED 4/20/59
23a. BURIAL CREMATION CREMATION	23b. DATE 4-20-59	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN CEM.	23d. LOCATION (City, town, or country) (State) BELLEFONTAINE, MO
24. FUNERAL DIRECTOR SCHRADER F.H., BALLWIN, MO		25. DATE RECD. BY LOCAL REG. 4-20-59	26. REGISTRAR'S SIGNATURE John C. Murphy, MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL diseases in Part I must be causally related.

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 *Richard Bopp*

Licensed Embalmer No. *4584*

P. O. Address *Baltimore, Md.*

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.