

Health, Welfare & Public Service  
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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018979  
STATE FILE NUMBER  
2 4491

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registr. No. 2 4491

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. GRAND, ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>5962 FLOY</b>	
Length of stay in 1b <b>59 days</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>W.</b> Last <b>BREIDING, SR.</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>6</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/21/81</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>LEBANON, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>GEORGE BREIDING</b>	13b. MOTHER'S MAIDEN NAME <b>LOUISA GETCHEL</b>	14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unknown) (If yes, give dates or dates of service) <b>YES SPAW</b>	16. SOCIAL SECURITY NO. <b>489-20-3505</b>	17. INFORMANT Address <b>VA HOSP. RECORDS, ST. LOUIS, MO.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RECURRENT SQUAMOUS CELL CARCINOMA TONSIL SECONDARY TO SQUAMOUS CELL CARCINOMA LARYNX</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 months 10 years</b>
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) <b>GENERALIZED ARTERIOSCLEROSIS</b>		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 checked="" 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 <b>St. Louis, Missouri</b>
21. I attended the deceased from <b>3/8/59</b> to <b>5/6/59</b> and last saw him alive on <b>5/6/59</b> Death occurred at <b>2:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>Stanton S. Sorokin M.D.</b>	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>5/6/59</b>

23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-8-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Picker Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR <b>Buchholz Mortuary</b>	ADDRESS <b>5967 W. Florissant</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 7 '59</b>	26. REGISTRAR'S SIGNATURE <b>Stan Smith, M.D.</b>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

*mil*

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

*Kurt J. Buchholz*

Licensed Embalmer No. *4551*

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.