

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 30 1959

59-041516
 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210596**

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis | | Length of stay in 1b 30 days | | c. CITY OR TOWN St Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR St Louis Little Rock Hosp INSTITUTION Inc | | | | d. STREET ADDRESS (If outside, give location) 3935 a Michigan | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Albert (ELMER Ernest) Bade | | | 4. DATE OF DEATH Month Day Year Nov 14, 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 2, 8, 1903 | 9. AGE (last birthday) 56 | IF UNDER 1 YEAR Months 9 Days 6 Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telephone Installer | | | 10b. KIND OF BUSINESS OR INDUSTRY aller Bell Telephone Co | | 11. BIRTHPLACE (City and state or country) Bradley, Ill. | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Ernest Bade | | | 13b. MOTHER'S MAIDEN NAME Reine Brouillette | | 14. NAME OF HUSBAND OR WIFE Lela Bade | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1920 to 1921 | | 16. SOCIAL SECURITY NO. 492-07-7211 | 17. INFORMANT Address Lela Bade 3935 a Michigan | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia, left (post-op.) DUE TO (b) CARCINOMA, Bronchogenic, Rt DUE TO (c) 1621 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 Day 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). GENERALIZED Arteriosclerosis | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 _____ a.m. _____ p.m. | Month, Day, Year | | | | | | |
| 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 Oct 19, 1959 to Nov 14, 1959 and last saw ^{her} him alive on Nov 13, 1959 Death occurred at 7, 45 am m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) John A. Carrier, MD | | | | 22b. ADDRESS 1755 So Grand Blvd | | 22c. DATE SIGNED 11-16-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Nov. 17, 1959 | 23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery St. Louis, Missouri | | 23d. LOCATION (City, town, or county) (State) | | | |
| 24. FUNERAL DIRECTOR ADDRESS Schumacher's 3013 Meramec St. | | | 25. DATE RECD. BY LOCAL REG. NOV 17 1959 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | |

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

710

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

Jack Haupt

Licensed Embalmer No. 4746

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.