

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039494
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3118

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS Length of stay in 1b 188 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILLINOIS b. COUNTY MADISON
c. CITY OR TOWN HIGHLAND Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 1804 WASHINGTON Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
RICHARD C. DRESTE 11-6-61

5. SEX MALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 8-5-22 9. AGE (last birthday) 39

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME HUGH A. DRESTE 13b. MOTHER'S MAIDEN NAME PEARL GLASSMAKER 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) YES WW-2 17. INFORMANT Address Illinois MRS. PEARL DRESTE, 1804 Washington, Highland,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
DUE TO (b) PYLELOCYSTITIS, CHRONIC 6 MONTHS
DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) WILSON'S DISEASE, FAR ADVANCED PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 5-2-61 to 11-6-61 and ~~XXXXXX~~
Death occurred at 6:55 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Anthony Cerskus (Degree or title) M.D. 22b. ADDRESS VA HOSP. JEFF. BRKS. MO. 22c. DATE SIGNED 11-6-61

23a. BURIAL, CREMATION, or REMOVAL (Specify) REMOVAL 23b. DATE 11-6-61 23c. NAME OF CEMETERY OR CREMATORY HIGHLAND, ILL. 23d. LOCATION (City, town, or county) (State) ILL.

24. FUNERAL DIRECTOR ADDRESS Spengler-Bou langer HIGHLAND ILL. 25. DATE RECD. BY LOCAL REG. 11-6-61 26. REGISTRAR'S SIGNATURE [Signature]

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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 Not Embalmed, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Joseph J. Kearby

Licensed Embalmer No. 7541

P. O. Address E. 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.