

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43132

State File No. 17342

1003

Registrar's No. 11342

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission). a. STATE Missouri b. COUNTY 2099	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4541 Pope Ave.		d. STREET ADDRESS (If rural, give location) 4541 Pope Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Joseph	b. (Middle) -----	c. (Last) Lizotte	4. DATE OF DEATH (Month) (Day) (Year) Dec. 19. 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 28 1872	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leather Inspector		10b. KIND OF BUSINESS OR INDUSTRY Shoe Worker		11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Joseph Lizotte	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Margaret Lizotte
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY (If you give year or dates otherwise) 488-07-7946	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harry Fabers 4541 Pope Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		5 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Arteriosclerosis DUE TO (c)		10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H221

22. I hereby certify that I attended the deceased from 10-13, 1951, to 12-19, 1951, that I last saw the deceased alive on 12-19, 1951, and that death occurred at 10:00 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Eugene L. Arnold M.D.	23b. ADDRESS 8700 Partridge	23c. DATE SIGNED 12/21/51
24a. BURIAL OR CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/22/51	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 2 1951 [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. A. Stock 2117 E. Grand.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

FILED JAN 10 1952

Eugene Arnold
8700 Partridge

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
Student Embalmer

Signed

Frank A. Moore

Licensed Embalmer No.

3041

P. O. Address

2117 E. Grand

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 this body is not embalmed, fact should be so stated above.