

FILED JUN 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 19979
5322

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO				c. LENGTH OF STAY (in this place)			
d. FULL NAME OF HOSPITAL OR INSTITUTION 3708 NEBRASKA				d. STREET ADDRESS (If rural, give location) 2249 3708 NEBRASKA			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) NICK			b. (Middle)			c. (Last) TOTH	
6. COLOR OR RACE			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			8. DATE OF BIRTH	
MALE			WHITE			MARRIED	
9. AGE (In years last birthday)			10. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country)	
77			RETIRED HAMMERSMITH			HUNGARY	
12. CITIZEN OF WHAT COUNTRY?			13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME	
8			PAUL TOTH			UNKNOWN	
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)			16. SOCIAL SECURITY NO.	
ANNA TOTH			NO			17. INFORMANT'S SIGNATURE OR NAME ADDRESS ANNA TOTH 3708 NEBRASKA	
18. CAUSE OF DEATH							
Enter only one cause per line for (a), (b), and (c)							
MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Occlusion of coronary artery							
INTERVAL BETWEEN ONSET AND DEATH Instantaneous							
ANTECEDENT CAUSES							
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.							
DUE TO (b) Arteriosclerotic heart disease							
DUE TO (c)							
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"/>			
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)	
						4200	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 2, 1949, to May 26, 1953, that I last saw the deceased alive on April 26, 1953 and that death occurred at 9:30A m., from the causes and on the date stated above.							
23a. SIGNATURE G. O. Brown M.D. (Degree or title)				23b. ADDRESS G. O. Brown, M.D., 1325 South Grand Blvd.		23c. DATE SIGNED 5/26/53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
REMOVAL		5-29-53		RESURRECTION		ST. LOUIS CO MO	
DATE REC'D BY LOCAL REG. MAY 27 1953		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. BURIAL DIRECTOR'S SIGNATURE Thomas Kuetis 2906 GRAVOIS		ADDRESS	

G.P. (Licensed Embalmer's Statement on Reverse Side)

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 J. Homer E. Dill

Licensed Embalmer No. 4347

P. O. Address 2906 GRAVO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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