

FILED JUL 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24124
145

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY St. Charles

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.)
a. STATE Missouri b. COUNTY St. Charles

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles c. LENGTH OF STAY (In this place) 2-Wks. c. CITY OR TOWN St. Charles d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital e. STREET ADDRESS (If rural, give location) 423 Jackson Street 0923

3. NAME OF DECEASED (Type or Print) a. (First) Eunice b. (Middle) --- c. (Last) Montag 4. DATE OF DEATH (Month) (Day) (Year) July 11 1954

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH Oct. 4 1891 9. AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (City and State or Foreign Country) Illinois 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Means 13b. MOTHER'S MAIDEN NAME Martha Beltz 14. NAME OF HUSBAND OR WIFE Adolph Montag (Dec'd.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. Nil 17. INFORMANT'S SIGNATURE OR NAME Robert E. Montag ADDRESS St. Charles, Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephrosclerosis INTERVAL BETWEEN ONSET AND DEATH 15 mo.

ANTECEDENT CAUSES DUE TO (b) Generalized arteriosclerosis 5 yrs.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

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 NO

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) 440X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 6-30, 1954, to 7-11, 1954; that I last saw the deceased alive on 7-11, 1954, and that death occurred at 7:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Inscribed or titled) [Signature] 23b. ADDRESS 114 N. Main St., St. Chas., Mo. 23c. DATE SIGNED 7-12-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE July 14, 1954 24c. NAME OF CEMETERY OR CREMATORY Mendon Mausoleum 24d. LOCATION (City, town, or county) (State) Mendon, Illinois

DATE REC'D BY LOCAL REG. July 12-54 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS St. Charles, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Frank B. Amalos

Licensed Embalmer No.....
410

P. O. Address.....
St. Charles

**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.**