

FILED FEB 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2522

State File No.

318

1003

1021

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
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, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				STREET ADDRESS (If rural, give location) 9159 5401 Pennsylvania					
3. NAME OF DECEASED (Type or Print) a. (First) Mathias		b. (Middle) _____		c. (Last) Fingerlos		4. DATE OF DEATH (Month) (Day) (Year) Feb. 4, 1955			
5. SEX Male <input type="radio"/>		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Apr. 18 1883			
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months _____		IF UNDER 2 HRS. Hours _____		IF UNDER 3 HRS. Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY retired			11. BIRTHPLACE (City and State or Foreign Country) Austria			
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME EE Fingerlos		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Rosalie Fingerlos		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 488-03-0331		17. INFORMANT'S SIGNATURE OR NAME Louise Nickrel				ADDRESS 1540 2 Pennsylvania	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma Colon, Spleen flexure DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input checked="" 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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 153X					
22. I hereby certify that I attended the deceased from 1:45 , 19____, to 2:15 , 19____, that I last saw the deceased alive on 2:15 , 19____, and that death occurred at 9:10 A m., from the causes and on the date stated above.									
23a. SIGNATURE J.R. Crivione M.D.				(Degree or title)		23b. ADDRESS 1515 Lafayette		23c. DATE SIGNED 2-2-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/3/1955		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. FEB 3 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.				25. FUNERAL DIRECTOR'S SIGNATURE John L Ziegenhein & Sons		ADDRESS 7027 Gravois	

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 *Ronald C Benz*.....
Licensed Embalmer No. *4863*

P. O. Address *7027 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.