

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 2 1956

State File No. **22335**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547** Registrar's No. **1489**

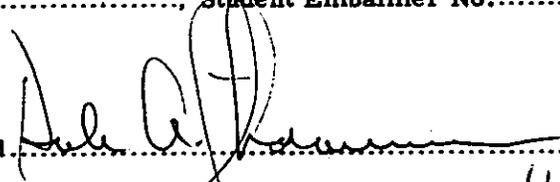
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Richmond Hts.)		c. LENGTH OF STAY (in this place) 1 Week	c. CITY OR TOWN Rock Hill
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		e. STREET ADDRESS (If rural, give location) 220 Eldridge Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) MIKE b. (Middle) _____ c. (Last) MOLINAR		4. DATE OF DEATH (Month) (Day) (Year) June 16 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sep 29, 1886
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer-Retired-Self Employed	11. BIRTHPLACE (City and State or Foreign Country) Italy
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer-Retired-Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Molinar		13b. MOTHER'S MAIDEN NAME Maryann Molinar	14. NAME OF HUSBAND OR WIFE Caterina Molinar
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Army 1923-1926		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Caterina Molinar ADDRESS 220 Eldridge Ave.
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) Uremia		INTERVAL BETWEEN ONSET AND DEATH 6/14/56	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Renal heart disease	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from 1952 to 6/16/56 , 19____, that I last saw the deceased alive on 6/16/56 , 19____, and that death occurred at 10:50A m., from the causes and on the date stated above.	
23a. SIGNATURE Duncan J. [Signature] (Degree or title) MD		23b. ADDRESS 3915 Watson	
23c. DATE SIGNED 6/18/56		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE June 19, 1956		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser ADDRESS 4228 S. Kingshighway Bl.	
DATE REC'D BY LOCAL REG. 6-18-56		REGISTRAR'S SIGNATURE Herbert B. Donhehd	

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 

Licensed Embalmer No. 453

P. O. Address

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.