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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32055

SL-10263 FILED SEP 26 1956

STATE FILE NUMBER

8376

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY MADISON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand, St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN MADISON	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Vet. Adm. Hospital		Length of stay in 1b 89 days		d. STREET ADDRESS 813 GRAND AVENUE (If outside, give location) 8128	
3. NAME OF DECEASED (Type or print) First MIDDLE Last FELIX S. GEOTSA			4. DATE OF DEATH Month Day Year 9-10-56		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-8-89	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER (Retired)		10b. KIND OF BUSINESS OR INDUSTRY STEEL FOUNDRY		11. BIRTHPLACE (City and state or country) POLAND #	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME STEVE GEOTSA			14. MOTHER'S MAIDEN NAME CATHERINE KABALSKI		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I		16. SOCIAL SECURITY NO. 318 12 1741		17. INFORMANT Address VA Hosp. Records, 915 N. Grand, St. Louis, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized lymphocytic leukemia					INTERVAL BETWEEN ONSET AND DEATH Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____ DUE TO (c) _____ 204.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 6-13-56 to 9-10-56 and last saw him alive on 9-10-56 Death occurred at 10:00 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Don M. Samples M.D.			22b. ADDRESS 915 N. Grand, VA Hosp. St. Louis, Mo.		22c. DATE SIGNED 9-10-56
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/11/56	23c. NAME OF CEMETERY OR CREMATORY National Cem.		23d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo.
24. FUNERAL DIRECTOR Edward Fendler 5611 South Grand Bl.		25. DATE RECD. BY LOCAL REG. SEP 11 1956		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

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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 *Harry J. Schuncke*

Licensed Embalmer No. *7167*

P. O. Address *564 S. G.*

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.