

FILED JUN 7 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19066

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4332**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Reside here before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS MO. 4000</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		Length of stay in lb <b>227</b>	d. STREET ADDRESS (If outside, give location) <b>KOCH HOSPITAL</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>MICHEL</b> Last			4. DATE OF DEATH <b>APRIL 17, 1957</b> Month Day Year
5. SEX <b>MALE</b> <input checked="" type="radio"/>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/10/94</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		100. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years last birthday) <b>62</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRED</b>		14. MOTHER'S MAIDEN NAME <b>MARY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>?? ?????</b>	
17. INFORMANT <b>ST. LOUIS CITY HOSP. RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of Right Mid Cerebral Artery</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tuberculosis (Inactive)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>20/15.</b>
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.) <b>332x A</b>		
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>		
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 <b>4/12/57</b> to <b>4/17/57</b> and last saw her alive on <b>4/17/57</b> Death occurred at <b>2:45 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22a. SIGNATURE (Degree or title) <b>John W. Stusich M.D.</b>		22c. DATE SIGNED <b>4/17/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>5-31-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Rowland-Aker Mortuary Service</b> 1104 Manchester Ave. St. Louis 10, Mo.		25. DATE RECD. BY LOCAL REG. <b>MAY 7 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> msb

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.