

STANDARD CERTIFICATE OF DEATH

FILED JAN 27 1958

47580

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

STATE FILE NUMBER

12207

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Affton		St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp.		d. STREET ADDRESS 9039 Kathleen Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last MARK S. JOST			4. DATE OF DEATH Month Day Year Dec. 17 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1951	9. AGE (In years last birthday) 6	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Child-St. George School		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Cornelius J. Jost Sr.		13b. MOTHER'S MAIDEN NAME Helen Stefanic		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Cornelius J. Jost Sr. 9039 Kathleen		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Post operative DUE TO (b) Tonsillectomy, Adenoidectomy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Status Lymphaticus 510.1					INTERVAL BETWEEN ONSET AND DEATH 13 1/2 hrs
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 <input type="checkbox"/> NOT WHILE 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 12-6-57 to 12-17-57 and last saw him alive on 12-17-57 Death occurred at 9:48 P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE C A Jester MD			22b. ADDRESS 5600 S Compton		22c. DATE SIGNED 12-19-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec. 20, 1957	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. DEC 19 57		26. REGISTRAR'S SIGNATURE J Carl Smith MD mfs	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

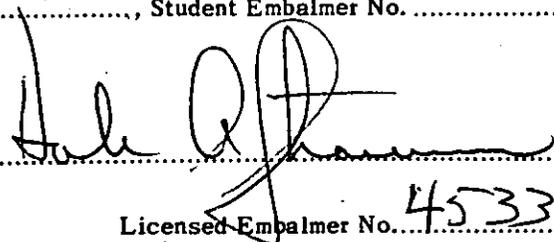
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. 4533.....

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.