

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 17 1958

2294
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 264

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Alexian Brother's</u>		Length of stay in lb <u>17 dys</u>		STREET ADDRESS (If outside, give location) <u>6470 Scanlan Ave.</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Irvine</u> Middle <u>Wm.</u> Last <u>Massot</u>			4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1896</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leather Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>California Tanning</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Benjamin Massot</u>		13b. MOTHER'S MAIDEN NAME <u>Kathryn Mumzlinger</u>	
14. NAME OF HUSBAND OR WIFE <u>Not married</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498 05 9719</u>	
17. INFORMANT Address <u>Miss Dorothy Massot 6470 Scanlan Ave.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Diabetic Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>260x</u> <u>Indefinite</u> <u>Indefinite</u>	
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 type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> - <input type="checkbox"/> - <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 WORK 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 Death occurred at <u>7:00 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.		I attended the deceased from <u>June 15-1957</u> and last saw him alive on <u>Jan 7-1958</u>			
22a. SIGNATURE <u>C. V. Wilcox M.D.</u> (Degree or title)		22b. ADDRESS <u>3176 Swank St. St. Louis, Mo.</u>		22c. DATE SIGNED <u>1-8-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 10, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		23e. (State)			
24. FUNERAL DIRECTOR <u>Hoffmeister Colonial Mortuary</u> <u>6464 Chippewa St., St. Louis, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 9 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u> <u>m JB</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

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 *Will C. Dranson*

Licensed Embalmer No. *4764*
P. O. Address *St Louis Mo*

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.