

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020080
State File No.

FILED MAY 23 1958

318

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5214
Registrar's No.

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|--|--|--|---|---|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> | | c. LENGTH OF STAY (in this place) <u>4mo 9dys</u> | | c. CITY OR TOWN <u>St. Louis</u> | | d. RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Louis Chronic Hospital</u> | | | | e. STREET ADDRESS (If rural, give location) <u>1012 Shenandoah</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> | | b. (Middle) _____ | | c. (Last) <u>Rimincsan</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 16, 1958</u> | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u> | | 8. DATE OF BIRTH <u>10-25-1872</u> | |
| 9. AGE (In years last birthday) <u>85</u> | | IF UNDER 1 YEAR Months _____ | | IF UNDER 1 YEAR Days _____ | | IF UNDER 1 HR. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Hungary</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>Joseph Rimincsan</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Lora Dupnia</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Deceased</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. _____ | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Eugene Ebel - 4814 Calvin</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u> | | | | <u>3 mths.</u> | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic H.T. Disease</u> | | | | <u>4 mos.</u> | |
| | | DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | | <u>4 mos.</u> | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION <u>Term. Bronchopneumonia</u> | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>420.0</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 6</u> , 19 <u>58</u> , to <u>May 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>58</u> , and that death occurred at <u>10:30A.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u> | | | | 23b. ADDRESS <u>5800 Arsenal</u> | | 23c. DATE SIGNED <u>5/16/58</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>5-20-1958</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemeter.</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>MAY 17 58</u> | | REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edw. Kochron - 3518 E. 14th</u> | | | |

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

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. 4800
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.