

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030721

STATE FILE NUMBER

8009

FILED AUG 28 1958

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		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>02 Alexian Bros.</i>		Length of stay in lb <i>2019</i>		d. STREET ADDRESS (If outside, give location) <i>6435 Virginia</i>	
3. NAME OF DECEASED (Type or print) First <i>FROHAN</i> Middle <i>MAGAZ</i> Last <i>MAGAZ</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>15</i> Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 7 1876</i>	9. AGE (In years last birthday) <i>81</i> Months <i>5</i> Days <i>2</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Labour</i>		11. BIRTHPLACE (City and state or country) <i>Spain</i>	
13. FATHER'S NAME <i>Anthony Magaz</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Lastra</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>489-05-2203</i>		17. INFORMANT Address <i>Marisa Magaz 6435 Virginia</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial occlusion</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Myocardial damage</i> DUE TO (c) <i>Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>42.0.1</i>					
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 <i>11-26-55</i> , to <i>8-14-58</i> and last saw her him alive on <i>8-14-58</i> Death occurred at <i>7:15 P.M.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Edith Muthler MD</i>		22b. ADDRESS <i>5600 S Compton</i>		22c. DATE SIGNED <i>8-16-58</i>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Nurse</i>		23b. DATE <i>8/19/58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Hope CEM.</i>	
23d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Mo.</i>		24. FUNERAL DIRECTOR ADDRESS <i>JOB. P. FENDLER JR. 7128 BIRCHGATE</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 18 58</i>	
26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>					

MEDICAL CERTIFICATION

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

Dr C Kuebel
or
Dr Hartman

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 *Howey Kahle*
Licensed Embalmer No. *759*
P. O. Address *Florissa*

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