

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030771

STATE FILE NUMBER

FILED AUG 28 1958 Registration District No.

318 Primary Registration District No. 1003

Registrar's No. 7655

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hosp.		d. STREET ADDRESS (If outside, give location) 5291 Washington Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM R. MONTZ		4. DATE OF DEATH Month Day Year AUGUST 4th, 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Set Up Man		10b. KIND OF BUSINESS OR INDUSTRY Emerson Elec.	11. BIRTHPLACE (City and state or country) Indiana
13a. FATHER'S NAME SAMUEL MONTZ		13b. MOTHER'S MAIDEN NAME MAY DORMAN	14. NAME OF HUSBAND OR WIFE ANITA LOUISE MONTZ
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch or dates of service) UNK.		16. SOCIAL SECURITY NO. UNK.	17. INFORMANT Anita Louise Montz 5291 Washington Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - Active Set. Head Strain - Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) : DUE TO (c) : PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 420.0
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <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 7-29-58 to 8-4-58 and last saw him alive on 8-4-58. Death occurred at 10:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Emanuel Bernick M.D.		22b. ADDRESS 453 N. Taylor	
		22c. DATE SIGNED 8/5/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/7/58	
23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR Herman Rindskopf Inc. 5216 Delmar		25. DATE RECD. BY LOCAL REG. AUG 7 '58	
26. REGISTRAR'S SIGNATURE Carl Smith M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

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 *W. B. Lee*

Licensed Embalmer No. *3691*
P. O. Address *St. Louis*

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.