

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035097  
STATE FILE NUMBER

FILED OCT 14 1958

Registration District No. 317 Primary Registration District No. 520 Registrar's No. 2547

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>Normandy</b> (If outside corporate limits, give TOWNSHIP only)		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Moline</b> <b>4000</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>O'Sullivan Nursing 5 Mo.</b>		Length of stay in 1b <b>5 Mo.</b>	d. STREET ADDRESS (If outside, give location) <b>2219 Lovett</b>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <b>Mary Kay</b>	First <b>Home</b> Middle <b>Middle</b> Last <b>Kay</b>	4. DATE OF DEATH Month <b>10</b> Day <b>1</b> Year <b>1958</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1878</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>- Ills.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Fred Hanbaum</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Karl Kay</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Bernice Foppiano, 2219 Lovett</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thromboses (multiple)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>	
	DUE TO (c) <b>332X</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Parkinson's syndrome</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2.
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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.)
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20c. TIME OF INJURY Hour <b>4:30</b> Month, Day, Year <b>May 1, 1958</b> 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 <b>Moline</b>	COUNTY <b>Ills.</b>	STATE <b>Ills.</b>
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21. I attended the deceased from Death occurred at <b>May 1, 1958 4:30 P.m.</b> to <b>Oct 1, 1958</b> and last saw her alive on <b>9/29/58</b> and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Lewis Litzmann MD</b> (Degree or title)	22b. ADDRESS <b>8231 Clayton Rd (17)</b>	22c. DATE SIGNED <b>10/3/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>10/4/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
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24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>	ADDRESS <b>1905 Union Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>10-3-58</b>	26. REGISTRAR'S SIGNATURE <b>Hubert B. Dombke MD</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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Dr. Lewis Littman  
8231 Clayton  
Pa 7-0202  
Hrs. 3-5 P.M.

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 *Albert R. Thompson*

Licensed Embalmer No. *4237*

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.