

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041293

STATE FILE NUMBER

FILED NOV 18 1958

Registration District No.

318

Primary Registration District No.

1003

10421

300
1-57
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Affton 4830	
FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 27 8200 Kammerer Rd.	
3. NAME OF DECEASED (Type or print) First ALFONS Middle BIRK Last		4. DATE OF DEATH Month Day Year Oct. 29 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 July 26, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Tavern	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown Bauer		13b. MOTHER'S MAIDEN NAME Regina Birk	14. NAME OF HUSBAND OR WIFE Gertrude Birk
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year and dates of service) Yes World War 2		16. SOCIAL SECURITY NO. 493-09-6656	17. INFORMANT Address Gertrude Birk 8200 Kammerer Rd.
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>Severe Edema & Necrosis of Frontal Lobes of Brain</u> DUE TO (b) <u>Metastatic Carcinoma of Brain</u> DUE TO (c) <u>Adeno-Carcinoma of Right Axillary Fossa.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 193.0			INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 3 mths
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 <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 _____ to <u>Death</u> and last saw ^{him} alive on <u>Oct. 28, 1958</u> Death occurred at <u>7:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Louis J. Birsner</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>634 N. Grand</u>	22c. DATE SIGNED <u>10/30/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Nov. 3, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 30 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *William B White*

Licensed Embalmer No. *4391*
P. O. Address *228 N. ...*

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.