Health, & Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-046806
STATE FILE NUMBER

FILED JAN 6 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3425

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY OR TOWN HATHAWAY HILLS Mo. Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 9229 ASTORIA DR. Length of stay in 1b YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST LOUIS
c. CITY OR TOWN HATHAWAY HILLS 4920 Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 9229 ASTORIA DR Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First LOUIS Middle R. Last MILENTZ

4. DATE OF DEATH Month DEC. Day 28 Year 1958

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAR. 28 1912
9. AGE (In years last birthday) 46 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN
10b. KIND OF BUSINESS OR INDUSTRY ANHEUSER-BUSCH
11. BIRTHPLACE (City and state or country) ST. LOUIS Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME CHARLES R. MILENTZ
13b. MOTHER'S MAIDEN NAME MARY E. YOUNG
14. NAME OF HUSBAND OR WIFE VIRGINIA MILENTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 489-07-6511
17. INFORMANT VIRGINIA MILENTZ Address 9229 ASTORIA DR

MEDICAL CERTIFICATION

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 — INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR
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) 4201

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Jan 1956 to Death and last saw him alive on DEC. 15, 1958
Death occurred at 5:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Lawrence M. Lawton (Degree or title) M.D.
22b. ADDRESS 3100 N. Kingshighway
22c. DATE SIGNED 12-30-58

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE DEC. 31 1958
23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL
23d. LOCATION (City, town, or county) ST. LOUIS (State) Mo.

24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois
25. DATE RECD. BY LOCAL REG. 12-30-58
26. REGISTRAR'S SIGNATURE Herbert P. Domke M.D.

(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.

1-3 Mon + Tue

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 Eleanor Rovince

Licensed Embalmer No. 3403

P. O. Address Jennings

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.