THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006980
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1561

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST. LOUIS Mo — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: 4575 - VARRELMAN — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS: 4575 - VARRELMAN (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JULIA Middle — Last CHRISTMAN

4. DATE OF DEATH: Month FEB. Day 11 Year 1959

5. SEX: Female

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 5 1908

9. AGE (In years last birthday): 51 — 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): RETIRED PRESS OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: JOHN KRAWIECKI

13b. MOTHER'S MAIDEN NAME: STELLA MAJEWSKI

14. NAME OF HUSBAND ~~OR WIFE~~: JULIUS CHRISTMAN

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.: —

17. INFORMANT: JULIUS CHRISTMAN — Address: 4575 - VARRELMAN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Seconds
DUE TO (b) Chronic Myocarditis — 1 yr.
DUE TO (c) 4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Chronic Arthritis
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 1-28-58, to 9-10-58 and last saw her/him alive on 9-10-58
Death occurred at 10:30 pm Feb 11, 1959 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John G. Crawford (Degree or title) M.D.
22b. ADDRESS: 7612 S. Broadway
22c. DATE SIGNED: 2-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: FEB. 14 1959
23c. NAME OF CEMETERY OR CREMATORY: NEW ST. MARCUS
23d. LOCATION (City, town, or county): ST. LOUIS (State): Mo

24. FUNERAL DIRECTOR: Thomas Kutis — ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: FEB 13 '59
26. REGISTRAR'S SIGNATURE: Hoard Smith. 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.

TW 2-3017

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 Frank C Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Fran

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.