

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011470

STATE FILE NUMBER

2195

FILED MAR 17 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY <u>City of St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Granite City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hosp</u>		Length of stay in lb <u>60 days</u>	
d. STREET ADDRESS <u>2246 Delmar Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Aranas</u> Middle _____ Last <u>Vartanian</u>			4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>59</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1880</u>
9. AGE (In years last birthday) <u>78</u>		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) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Armenia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Vartan Vartanian</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Biazar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>--</u>	17. INFORMANT <u>Biazar Vartanian</u> Address: <u>2264 Delmar Granite City, Ill.</u>
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>Generalized Septicemia</u> DUE TO (b) <u>Necrotizing Papillitis</u> DUE TO (c) <u>Diabetes mellitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Heart Block</u>			INTERVAL BETWEEN ONSET AND DEATH <u>19 Days</u> <u>1 month</u>
19. WAS AUTOPSY PERFORMED? <u>YES</u> <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.) <u>-</u>		20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT WORK <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.) <u>-</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>-</u>
21. I attended the deceased from <u>Jan 26, 1959</u> to <u>March 1, 1959</u> and last saw ^{her} him alive on <u>March 1, 1959</u> Death occurred at <u>12:25 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert Rubin M.D.</u>		22b. ADDRESS <u>216 S. Kings Highway</u>	22c. DATE SIGNED <u>3/2/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-1-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Edwardsville Twp. Illinois</u>
24. FUNERAL DIRECTOR <u>Mercer Funeral Home Granite City, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 3 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Spinston C. Williams*

Licensed Embalmer No. *5016*

P. O. Address *Gronite City*

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.