Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011859
STATE FILE NUMBER

FILED APR 14 1959 Registration District No. 317 Primary Registration District No. 600 Registrar's No. 902

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN GARDENVILLE — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4649 HEIDELBERG — Length of stay in 1b YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY ST. LOUIS
c. CITY OR TOWN GARDENVILLE 4810 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 4649 HEIDELBERG — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First MATT Middle Last LONCARIC

4. DATE OF DEATH Month APRIL Day 1 Year 1959

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH OCT 24, 1888 9. AGE (In years last birthday) 70 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) STONE MASON
10b. KIND OF BUSINESS OR INDUSTRY BUILDING
11. BIRTHPLACE (City and state or country) YUGOSLAVIA 6
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME MATT LONCARIC
13b. MOTHER'S MAIDEN NAME MARY KISSEL
14. NAME OF HUSBAND OR WIFE THERESA

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. 498-03-5687
17. INFORMANT THERESA LONCARIC Address 4649 HEIDELBERG

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of the liver
DUE TO (b) Chronic Nephritis
DUE TO (c)
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) 1561

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 10/21/58, to 4/1/59 and last saw him alive on 4/1/59
Death occurred at 4/1/59 9:56A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Otto C. Hanser MD (Degree or title)
22b. ADDRESS 3012 Lafayette
22c. DATE SIGNED 4/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 4/4/1959
23c. NAME OF CEMETERY OR CREMATORY SS PETER & PAUL CEM
23d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.

24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS ADDRESS 7027 GRAVOIS
25. DATE RECD. BY LOCAL REG. 4-2-59
26. REGISTRAR'S SIGNATURE John C. Murphy, MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Social, cerebral, or other cardiovascular diseases in item 18 are symptoms and not causes. 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 Donald E Berry

Licensed Embalmer No. 4863

P. O. Address St. Louis Mo

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.