

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015323

STATE FILE NUMBER

3261

FILED APR 20 1959

Registration District No. Primary Registration District No.

Registrar No. 3261

300,
1-57
92
0

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</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>1718 So. 9th ST.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1718 So. 9th ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARIA</u> Middle Last <u>LITTICH</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1959</u>		
5. SEX <u>1</u> <u>FEMALE</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>JAN 24 1874</u>	9. AGE (In years last birthday) <u>85</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>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>GERMANY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13a. FATHER'S NAME <u>JOHN JOST</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN LITTICH</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>NONE</u>	17. INFORMANT Address <u>JOHN LITTICH 1718 So 9th ST.</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>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>MITRAL INSUFFICIENCY</u> DUE TO (c) <u>4210</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> <u>5 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 WORK <input type="checkbox"/> 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 <u>MAR. 20-59</u> to <u>MAR 31-59</u> and last saw her alive on <u>MAR 31-59</u> Death occurred at <u>11 P. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Dress or title) <u>Phillard J Nash D.O.</u>			22b. ADDRESS <u>1829 S 18th</u>		22c. DATE SIGNED <u>4/1/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL 3 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutie 2906 Gravois</u>			25. DATE RECD. BY LOCAL REG. <u>APR 1 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

All diseases in Part must be causally related.
 Inquire: "Is due to mitral insufficiency?"
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MLC

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 Samuel C. White

Licensed Embalmer No. 4347

P. O. Address 2906 Pro

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.