

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019711  
STATE FILE NUMBER

2 4604

6743

HELD MAY 22 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Louis City Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>1433 - Destrehan</u>	
3. NAME OF DECEASED (Type or print) First <u>WALDO</u> Middle <u>BURTON</u> Last <u>TOZIER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>8th</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>2-11-1905</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bartender</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	9c. AGE (In years last birthday) <u>54</u>
10a. FATHER'S NAME <u>Charles Tozier</u>		10b. MOTHER'S MAIDEN NAME <u>Lilly Ruess</u>	10c. NAME OF HUSBAND OR WIFE <u>Vera Tozier</u>
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		12. SOCIAL SECURITY NO. <u>490-12-8509</u>	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Jaundice Curshous</u> DUE TO (c) <u>581.1</u>		14. INTERVAL BETWEEN ONSET AND DEATH	
15. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		16. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
17. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		18. CITY, TOWN, OR LOCATION COUNTY STATE	
19. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from Death occurred at <u>5:30PM</u> <u>4-29-59</u> to <u>5-8-59</u> and last saw her alive on <u>5-8-59</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>Belle J. Stein M.D.</u> 22b. ADDRESS <u>1515 Lafayette Ave</u> 22c. DATE SIGNED <u>5-8-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-11-59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co - Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Edw. Koch &amp; Son - 3576 E. 14th</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 9 '59</u>	
26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>		27. _____	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc., must state only standard nomenclature in item 18. No symptoms will be listed. 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 *Gustav W. J. [unclear]*  
Licensed Embalmer No. *4329*  
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.