

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023197

FILED JUN 18 1959

STATE FILE NUMBER  
2 5512

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Macoupin</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>White City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Length of stay in hospital <b>5 weeks</b>	d. STREET ADDRESS (If outside, give location) <b>Rural Route No. 1</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Matt</b> Middle <b>Mihelcic</b> Last <b>Mihelcic</b>			4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 20, 1895</b>	9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>	11. BIRTHPLACE (City and state or country) <b>Yugoslavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Henry Mihelcic</b>		13b. MOTHER'S MAIDEN NAME <b>Katie Muich</b>		14. NAME OF HUSBAND OR WIFE <b>Mary (Gorsicia) Mihelcic</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>342-10-0171</b>	17. INFORMANT Address <b>Mary Mihelcic, White City, Illinois.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lower lobe left lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Nodular hyperplasia prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <b>163x</b>		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from <b>5-11-59</b> to <b>6-8-59</b> and last saw her/him alive on <b>6-8-59</b> Death occurred at <b>4:45 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>C. E. Mueller, M.D.</b> (Degree or title)		22b. ADDRESS <b>634 N. Grand Blvd.</b>	22c. DATE SIGNED <b>6/9/59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-11-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Miners Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Mt. Olive, Illinois.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.,</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 9 59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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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 *Lamorne O. Herling* .....

Licensed Embalmer No. .... *4979* .....

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.