

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023228

STATE FILE NUMBER

2 5630

FILED JUN 24 1959

Registration District No.

Primary Registration District No.

Registrar's

S. 300

1-57

28

1292

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Hosp.		d. STREET ADDRESS (If outside, give location) 5229 Lisette ave.	
Length of stay in lb 3 minutes		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles -- Muschany			4. DATE OF DEATH Month Day Year June 11 1959
5. SEX Male o	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1894
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William Muschany		13b. MOTHER'S MAIDEN NAME Elizabeth Vogel	14. NAME OF HUSBAND OR WIFE Mathilde
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 500-42--0671	17. INFORMANT Address Mrs. Mathilde Muschany 5229 Lisette ave.
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 thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH 10-15 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			420.1
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 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.)	
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.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1945</u> to <u>1959</u> and last saw him <u>live on 6/10/59</u> Death occurred at <u>1.52 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>Julius Hopp M.D.</u>		22b. ADDRESS <u>462 N Taylor</u>	
		22c. DATE SIGNED <u>6/12/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 15, 1959	
23c. NAME OF CEMETERY OR CREMATORY Mount Hope Mausleum		23d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Rd. Lemay, Mo.	
24. FUNERAL DIRECTOR'S ADDRESS C. Hoelmeister Mortuaries 7814 S. Broadway		25. DATE REC'D. BY LOCAL REG. JUN 12 '59	
		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

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**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 *Bill C. Branson*

Licensed Embalmer No. 4764

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.