

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023250

STATE FILE NUMBER

2 5483

FILED JUN 18 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. _____

300

1-57

1/1

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
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.

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, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3550 Nebraska		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FRANK Middle Last OLLINGER			4. DATE OF DEATH Month JUNE Day 6 Year 1959		
5. SEX Male	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 Aug 26, 1889	9. AGE (In years last birthday) 69	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) Retired Tailor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Austria Hungary		12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME Joseph Ollinger		13b. MOTHER'S MAIDEN NAME Elizabeth Leese		14. NAME OF HUSBAND OR WIFE Ernestine Ollinger	
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. 488-01-1546	17. INFORMANT Address Ernestine Ollinger 3550 Nebraska		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia RLL					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Diabetes, Gangrene + BK amputation					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) Cerebral Thraubosis, LMCA					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260+					
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 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 St. Louis		COUNTY Mo. STATE
21. I attended the deceased from 5/29/59 to 6/6/59 and last saw ^{her} him alive on 6/6/59 Death occurred at 9:40 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Charles A. Egan M.D. (Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 6/8/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 10 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.		23d. LOCATION (City, town, or country) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois		25. DATE REG. BY LOCAL REG. JUN 9 '59		26. REGISTRAR'S SIGNATURE Neal Smith M.D. Mgr	

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address Jennings

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.