

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**59-023914**  
STATE FILE NUMBER

**FILED JUN 16 1959**

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 103

5. 300  
1-57

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 <u>VERNON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>WASHINGTON TOWNSHIP</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" 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) <u>HOSPITAL OR INSTITUTION STATE HOSP. # 3, NEVADA, MO</u>			Length of stay in lb <u>18 YRS. 8 MONTHS 5 DAYS</u>	d. STREET ADDRESS <u>609 CARRIE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>-</u> Last <u>HATZ</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 4. 1883</u>		9. AGE (In years last birthday) <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CANDY SHOP</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>-</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>HOSP. RECORDS STATE HOSP. # 3 NEVADA MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>GENERALIZED ART. SCLEROSIS</u> DUE TO (c) <u>A201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>FEW MINUTES</u> <u>MANY YEARS</u>	
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		COUNTY		STATE	
21. I attended the deceased from <u>OCT. 1. 1940</u> to <u>JUNE 6 1959</u> and last saw <sup>her</sup> him alive on <u>JUNE 6. 1959</u> Death occurred at <u>6:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>George Oster M.D.</u> (Degree or title)				22b. ADDRESS <u>STATE HOSP. # 3, NEVADA, MO</u>		22c. DATE SIGNED <u>6-6-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>June 8</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
24. FUNERAL DIRECTOR <u>Suedmeyer St. Louis, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>6-10-1959</u>		26. REGISTRAR'S SIGNATURE <u>Arnold &amp; Jerry</u>		

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 *[Signature]*....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *[Signature]*.....

Licensed Embalmer No. 4532.....

P. O. Address Florida - 11.....

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.