

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026320

FILED VS AUG 11 1959

Registration District No. 376 Primary Registration District No. 3061 Registrar's No. 295 STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Flat River</u>		Length of stay in 1b <u>41 Years</u>	c. CITY OR TOWN <u>Flat River</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1101 Jackson, St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1101 Jackson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>(None)</u> Last <u>Larowitz</u>			4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Layer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Nat. Gas. Co</u>	11. BIRTHPLACE (City and state or country) <u>Austria</u>	12. CITIZEN OF WHAT COUNTRY <u>Austria</u>
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13a. FATHER'S NAME <u>Mike Larowitz</u>	13b. MOTHER'S MAIDEN NAME <u>Katie Shosheck</u>	14. NAME OF HUSBAND OR WIFE <u>Ann Larowitz (Dec)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>492 16 7338</u>	17. INFORMANT <u>Mrs. Olga St James, Flat River</u>	Address
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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>Uremic Poison</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
DUE TO (b) <u>Nephritis</u>		
DUE TO (c) <u>arterio-sclerosis</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Age</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from <u>July 11/59</u> to <u>Aug 1/59</u> and last saw her alive on <u>Aug 1/59</u> Death occurred at <u>10:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>W. J. J. J. J.</u> (Degree or title)	22b. ADDRESS <u>Flat River Mo</u>	22c. DATE SIGNED <u>8/3/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/4/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Francois, Mo</u>
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24. FUNERAL DIRECTOR <u>W. J. J. J.</u>	ADDRESS <u>Flat River Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 3, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS  
AUG 12 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Desloge, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.