

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026589

FILED VS AUG 5 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-6902**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 77		c. CITY OR TOWN WATERLOO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 NO. GRAND AVE.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last ALVIN M. EINWICH				4. DATE OF DEATH Month Day Year 7/24/59									
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/28/17		9. AGE (last birthday) 42		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) COLUMBIA, ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME MATT EINWICH				13b. MOTHER'S MAIDEN NAME MARY BECKLE				14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WA-II				16. SOCIAL SECURITY NO. 332-12-8441		17. INFORMANT Address VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO (b) CARCINOMA OF ESOPHAGUS WITH TRACHEOESOPHAGEAL DUE TO (c) FISTULA, WITH METASTASIS TO LUNGS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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										INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS			
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"/> NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 150x									
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year													
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 VA 5/5/59 , to 7/24/59 and last saw him YET live on 7/24/59 Death occurred at 9:40 AM m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) HERMAN E. RUSSELL M.D.				22b. ADDRESS VAH, ST. LOUIS, MO.				22c. DATE SIGNED 7/24/59					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Jul 25, 1959		23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul		23d. LOCATION (City, town, or county) (State) Waterloo, Illinois							
24. FUNERAL DIRECTOR Emil Quersheim ADDRESS Waterloo, Illinois				25. DATE RECD. BY LOCAL REG. JUL 25 59		26. REGISTRAR'S SIGNATURE Earl Smith M.D.							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Irana Prokoff*

Licensed Embalmer No. 4356

P. O. Address St. Louis

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.