

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 11 1959

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59-026765

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL		d. STREET ADDRESS (If outside, give location) 2712 INDIANA	

3. NAME OF DECEASED (Type or print) First Middle Last JACOB A HOLTZMANN			4. DATE OF DEATH Month Day Year JULY 18 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 OCT 28 1883	9. AGE (last birthday) 75	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED AUTO MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) INDIANA		12. CITIZEN OF WHAT COUNTRY U-S-A	
13a. FATHER'S NAME JACOB HOLTZMANN			13b. MOTHER'S MAIDEN NAME MARY RIEHL		14. NAME OF HUSBAND OR WIFE IDA HOLTZMANN		
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. NONE		17. INFORMANT Address IDA HOLTZMANN 2712 INDIANA			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatosis DUE TO (b) Carcinoma of Intestine DUE TO (c) 153.9		INTERVAL BETWEEN ONSET AND DEATH
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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	
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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	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 July 4th 1959 and last saw him alive on July 18, 1959 Death occurred at 3:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Paul B. Webb, M.D.		22b. ADDRESS 1915th Sedney St.		22c. DATE SIGNED 7/21/59
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23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JULY 22 1959	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM	23d. LOCATION (City, town, or county) ST. LOUIS MO
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24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois	25. DATE RECD. BY LOCAL REG. JUL 21 '59	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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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

Frank C. Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Du

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.