

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 30 1959

59-026973

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 6807** 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	Length of stay in lb lmo 24dys	c. CITY OR TOWN St. Louis	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3123 Lemp
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Elizabeth Middle Molitor Last			4. DATE OF DEATH Month July Day 19 Year 1959		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-31-1878	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) Romania	12. CITIZEN OF WHAT COUNTRY U-S-A.	
13a. FATHER'S NAME JACOB KLEIN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE JOSEPH MOLITOR	
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 HELEN MOLITOR 3123 LEMP AVE		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral Thrombosis, Recurrent		10 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Arteriosclerosis 443X	yo
	DUE TO (c) Hypertensive Cardiovascular Disease	yo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Broncho pneumonia		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

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.)	
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 May 25, 1959 to July 19, 1959 and last saw her alive on July 19, 1959		Death occurred at 9:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE George M. Janaka, M.D. (Degree or title)		22b. ADDRESS 5600 Arsenal	22c. DATE SIGNED 7/20/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 22 1959	23c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
24. FUNERAL DIRECTOR Thomas Kutis 1906 GRAVOIS. ADDRESS		25. DATE RECD. BY LOCAL REG. JUL 21 '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 _____, Student Embalmer No. _____

or by _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4347

P. O. Address 2906 S

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.