

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030236

FILED VS AUG 3 1 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-7426**

DEED

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

a. COUNTY: **Missouri** b. COUNTY: **St. Louis**
 b. CITY: **Saint Louis** Length of stay in lb: **9 Weeks**
 c. CITY OR TOWN: **Lemay (25)** Inside Limits: Yes No
 c. FULL NAME OF (If NOT in hospital, give location): **Alexian Brothers** Yes No
 d. STREET ADDRESS: **216 Nellie Ave.** Reside on Farm: Yes No

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
5. SEX			6. COLOR OR RACE		
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>			8. DATE OF BIRTH		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME		

3. NAME OF DECEASED: **CASPER H. BAST** 4. DATE OF DEATH: **Aug. 8, 1959**
 5. SEX: **Male** 6. COLOR OR RACE: **White**
 7. Married Never Married
 Widowed Divorced
 8. DATE OF BIRTH: **Oct. 13, 1885 73**
 10a. USUAL OCCUPATION: **Carpenter** 10b. KIND OF BUSINESS OR INDUSTRY: **Retired**
 11. BIRTHPLACE: **Mattese, Mo.** 12. CITIZEN OF WHAT COUNTRY: **U.S.A.**
 13a. FATHER'S NAME: **Mathias Bast** 13b. MOTHER'S MAIDEN NAME: **Margalen Schmidt**
 14. NAME OF HUSBAND OR WIFE: **Mary A. Bast**
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? **No.** 16. SOCIAL SECURITY NO.: **494-05-9284**
 17. INFORMANT: **Mary A. Bast** Address: **216 Nellie Ave (25)**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY		
IMMEDIATE CAUSE (a)		
carcinoma of stomach		
CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

18. CAUSE OF DEATH: **generalized abdominal carcinomatosis**
 IMMEDIATE CAUSE (a): **carcinoma of stomach**
 DUE TO (b): **carcinoma of stomach**
 DUE TO (c): **151+**
 INTERVAL BETWEEN ONSET AND DEATH: **4 mos**

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	

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	Month, Day, Year	

19. WAS AUTOPSY PERFORMED? YES NO
 20a. ACCIDENT SUICIDE HOMICIDE
 20b. DESCRIBE HOW INJURY OCCURRED: _____
 20c. TIME OF INJURY: _____

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 _____ and last saw him live on _____				
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.				

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
 20e. PLACE OF INJURY: _____
 20f. CITY, TOWN, OR LOCATION: _____ COUNTY: _____ STATE: _____
 21. I attended the deceased from **Miss 1959** and last saw him live on **4 Aug 59**
 Death occurred at **3:30 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE		22b. ADDRESS		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE

22a. SIGNATURE: **Louis T. Litzow** (Degree or title) **M.D.** 22b. ADDRESS: **634 No. Grand**
 22c. DATE SIGNED: **10 Aug 59**
 23a. BURIAL, CREMATION, REMOVAL (Specify): **Removal** 23b. DATE: **Aug. 11, 1959**
 23c. NAME OF CEMETERY OR CREMATORY: **Mt. Hope Cemetery** 23d. LOCATION (City, town, or county) (State): **Lemay (25) Missouri**
 24. FUNERAL DIRECTOR: **Fendler Und. Co. 7420 Michigan Ave.** 25. DATE RECD. BY LOCAL REG.: **AUG 10 '59**
 26. REGISTRAR'S SIGNATURE: **Earl Smith, M.D.**

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Lewis J. Litzow
710 Elberta Bldg
J. S. - 1879

2:30 Mon 1/20/19
1/20/19

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Me

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.