RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030620

FILED VS AUG 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7434 STATE FILE NUMBER

DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri.
Length of stay in 1b: 5 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Alexian Brothers Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3933 South Broadway
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Firmin; Middle:; Last: Mandeville
4. DATE OF DEATH: Month: August; Day: 8; Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/13/88
9. AGE (last birthday): 70
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HR: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious Brother
10b. KIND OF BUSINESS OR INDUSTRY: Religious
11. BIRTHPLACE (City and state or country): Nebraska
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unavailable Mandeville
13b. MOTHER'S MAIDEN NAME: Unavailable
14. NAME OF HUSBAND OR WIFE: Nil
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): Nil
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Alexian Brothers Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular — 5 yrs.
DUE TO (c): Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4221
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 July 1, 1958 to Aug 8, 1959 and last saw her/him alive on Aug 8, 1959
Death occurred at 12:00 Noon m on the date stated above, and to the best of my knowledge from the causes stated.
22a. SIGNATURE (Degree or title): J. Czopiek M.D.
22b. ADDRESS: 1901 Madison St.
22c. DATE SIGNED: 8/8/59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8/10/59
23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
23d. LOCATION (City, town, or county) (State): South Bend, Indiana.
24. FUNERAL DIRECTOR: Albert H. Hoppe
ADDRESS: 4700 Washington Blvd.,
25. DATE REC'D. BY LOCAL REG.: AUG 10 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 _____ Signed Elmo R Sadwe

Signature of Student Embalmer

Licensed Embalmer No. 4077

P. O. Address St Lou

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