

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH 2, 8212 59-034028
FILED VS SEP 21 1959 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 <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. John's Hospital</i>		d. STREET ADDRESS (If outside, give location) <i>5926 LOUGHBOROUGH</i>	

3. NAME OF DECEASED (Type or print) First <i>ALICE</i> Middle <i>C</i> Last <i>LEISTRITZ</i>			4. DATE OF DEATH Month <i>SEPT</i> Day <i>4</i> Year <i>1959</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>3/22/1877</i>	9. AGE (last birthday) <i>82</i>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AT HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>MICHAEL, ILL.</i>	
12. CITIZEN OF WHAT COUNTRY <i>USA</i>					

13a. FATHER'S NAME <i>AUGUST MILLER</i>		13b. MOTHER'S MAIDEN NAME <i>MARY CALVEY</i>		14. NAME OF HUSBAND OR WIFE <i>DECEASED</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>5926 HAROLD LEISTRITZ LOUGHBOROUGH</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arterio Sclerosis Heart Disease</i>		
DUE TO (c) <i>Cerebral hemorrhage mild</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>420.0</i>	
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 <i>9/2/59</i> to <i>9/4/59</i> and last saw her/him alive on <i>9/3/59</i> Death occurred at <i>5:45 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <i>J. Catanzaro M.D.</i>		22b. ADDRESS <i>2705 Chestnut</i>		22c. DATE SIGNED <i>9/4/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>9/6/1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HARDIN, ILLINOIS</i>	

24. FUNERAL DIRECTOR ADDRESS <i>J L ZIEGENHEIN & SONS 7027 GRAVOIS</i>		25. DATE RECD. BY LOCAL REG. <i>SEP 4 1959</i>		26. REGISTRAR'S SIGNATURE <i>Loed Smith. M.D.</i>	
---	--	---	--	--	--

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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ronald E. Berg

Licensed Embalmer No. 4863

P. O. Address St. Louis, Mo.

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.