

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034106

FILED VS OCT 15 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **3 9106**

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 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN DESLOGE		d. STREET ADDRESS (If outside, give location) 5217^e MIAMI	
3. NAME OF DECEASED (Type or print) First THADDEUS Middle Last MILLFELT		4. DATE OF DEATH Month OCT Day 1 Year 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 18 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY HAMPTON ELEC.	9. AGE (last birthday) 46
11. BIRTHPLACE (City and state or country) ST. LOUIS MO		12. CITIZEN OF WHAT COUNTRY U-S-A	
13a. FATHER'S NAME LUCIAN MILLFELT		13b. MOTHER'S MAIDEN NAME RUBY SMITH	
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. 333-03-5881	
17. INFORMANT SIDONIA MILLFELT		Address 5217^e MIAMI	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO (b) GASTROINTESTINAL HEMORRHAGE DUE TO (c) GASTRIC CARCINOMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Metastatic CARCINOMA			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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 ST. LOUIS		COUNTY MO	
20g. STATE MO		21. I attended the deceased from OCT 1 1959 to OCT 1 1959 and last saw him alive on OCT 1 1959 Death occurred at 9:50 A on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) James A. McCool, M.D.		22b. ADDRESS 1325 S. GRAND	
22c. DATE SIGNED 10/5/59		23. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE OCT 5 1959	
23c. LOCATION (City, town, or county) ST. LOUIS		23d. STATE MO	
24. FUNERAL DIRECTOR Thomas Kutia		25. DATE RECD. BY LOCAL REG. OCT 5 59	
26. ADDRESS 2906 Gravois		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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eileen P. Poirier

Licensed Embalmer No. 3403

P. O. Address 2906 Grove

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.