

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034111

FILED VS OCT 5 1959

2 8685

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri.		Length of stay in 1b 3 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 15 Kingsbury Place., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Joseph Middle Thomas Last Mittong	4. DATE OF DEATH Month September Day 19 Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/3/1940	9. AGE (last birthday) 19	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY St. Louis University	11. BIRTHPLACE (City and state or country) St. Louis, Missouri.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Joseph F. Mittong	13b. MOTHER'S MAIDEN NAME Marie Thomas	14. NAME OF HUSBAND OR WIFE Nil
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No Nil	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Joseph F. Mittong,	Address 15 Kingsbury Place.,
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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>Fracture in the occiput extending clear down into the base with profuse hemorrhages throughout the left hemisphere, suffered when struck by limb of tree which deceased was removing in driveway of home on Sept. 16, 1959</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>accident</i>	
DUE TO (c)	

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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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>See above</i>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 9-16-59

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.) 852 home	20f. CITY, TOWN, OR LOCATION St. Louis Missouri	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at **2:45 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Patrick E. Taylor Coroner</i>	22b. ADDRESS 1300 Clark Ave	22c. DATE SIGNED 9-21-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/22/1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri.	(State)
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington	ADDRESS	25. DATE RECD. BY LOCAL REG. SEP 21 '59	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>
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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 _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Wash
St. Louis, Mo.

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.