

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 5 1959

59-034314

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 8804**

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>4548 Gibson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Matilda</b> Middle <b>CATHERINE</b> Last <b>SEITZ</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>23,</b> Year <b>1959</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/21/1876</b>		9. AGE (last birthday) <b>83</b>		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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Cuba, Missouri.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>John Borth</b>			13b. MOTHER'S MAIDEN NAME <b>Augusta Aobilles</b>			14. NAME OF HUSBAND OR WIFE <b>John</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>Nil.</b>			17. INFORMANT Address <b>Mrs. Elsie Schuler, 4548 Gibson</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <b>420.0</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis Obliterans with gangrene of right foot if months</b>								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 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 _____ 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 _____ to <b>11/8/58</b>		_____ to <b>9/23/59</b>		and last saw her _____		_____ on <b>9/23/59</b>		Death occurred at <b>7:15 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. J. Vanilla, M.D.</i> (Degree or title) M. D.				22b. ADDRESS <b>BARNES HOSPITAL</b>				22c. DATE SIGNED <b>9/24/59</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-27-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kinder Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cuba, Missouri.</b>							
24. FUNERAL DIRECTOR <b>Hoener Funeral Home, Cuba, Missouri.</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 24 59</b>		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Sm*

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 *Robert Haines*

Licensed Embalmer No. 4108

P. O. Address *St. Louis*

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.

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