

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037607

FILED VS NOV 3 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9569**

ENDED

| | | | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|------------------------------|--------|-------|
| 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, MO. | | Length of stay in 1b | | c. CITY OR TOWN ST. LOUIS | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 8443 EAST COURT | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last TRISA TERESA GALBA | | | | 4. DATE OF DEATH Month Day Year Oct. 17 1959 | | | | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH JAN 10 1883 | 9. AGE (last birthday) 76 | 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) HOUSE WORK | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (City and state or country) AUSTRIA HUNGARY U-S-A | | 12. CITIZEN OF WHAT COUNTRY | | | | | |
| 13a. FATHER'S NAME NICK WERNINGER | | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | 14. NAME OF HUSBAND OR WIFE JOSEPH GALBA | | | | | | |
| 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. NONE | | 17. INFORMANT Address MARIE A KUDA 6443 EAST COURT | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade + hemopericardium | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 min. | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Rupture of myocardium | | | | 2 min. | | | | | |
| | | DUE TO (c) Myocardial infarct 2° to occlusion of coronary artery 2 days | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1 | | | | | 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.) 420.1 | | | | | | | |
| 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 15 Oct. 1959 to 17 Oct. 1959 and last saw her ^{him} alive on 17 Oct 59 Death occurred at 06:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Russell P. Cook Jr., M.D. | | | | 22b. ADDRESS 1515 LAFAYETTE AVE. | | | 22c. DATE SIGNED 17 Oct 59 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE OCT 19 1959 | 23c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL | | 23d. LOCATION (City, town, or county) (State) ST. LOUIS MO | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois | | | 25. DATE RECD. BY LOCAL REG. OCT 19 59 | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

Samuel C. White

Licensed Embalmer No. 4347

P. O. Address 2406 Park

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.