

PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS OCT 23 1959

59-037692

STATE FILE NUMBER

2 9414

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

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		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		d. STREET ADDRESS (If outside, give location) 2806 ACCOMAC	

3. NAME OF DECEASED (Type or print) First JAMES Middle T Last HITCH			4. DATE OF DEATH Month OCT Day 11 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 10 1894	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER STANDARD HOUSE + WINDOW CLEANING		10b. KIND OF BUSINESS OR INDUSTRY ILLINOIS		11. BIRTHPLACE (City and state or country) U-S-A	
13a. FATHER'S NAME EMORY HITCH		13b. MOTHER'S MAIDEN NAME HARRIET JOHNSON		14. NAME OF HUSBAND OR WIFE MATTIE HITCH	
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.		17. INFORMANT Address MATTIE HITCH 2806 ACCOMAC	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 19 2 1/2 15 1/2
IMMEDIATE CAUSE (a) Cholecystitis; Concomitant Liver (Tumor?)			
DUE TO (b) Probable fistula between gall bladder + colon			
DUE TO (c) 585x			
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

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 10/2 to 10/11 and last saw her/him alive on 10/10 . Death occurred at 3 15 A m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Ralph Berg MD		22b. ADDRESS 32038 Grand		22c. DATE SIGNED 10/11/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE OCT 14 1959	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO		
24. FUNERAL DIRECTOR ADDRESS Thomas Kuttis 2906 Gravois		25. DATE RECD. BY LOCAL REG. OCT 14 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. mdb		

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

Eleanor Rovine

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.