

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041964**

**FILED VS. NOV 19 1959**

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's **210216**

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>FRANKLIN</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND, ST LOUIS, MO.</b>		Length of stay in 1b <b>3 DAYS</b>		c. CITY OR TOWN <b>WASHINGTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET ADM. HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>510 W 5TH STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES G. HERZOG</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 5, 1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-93</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>JOE HERZOG</b>		13b. MOTHER'S MAIDEN NAME <b>BERTHA GRIEVE</b>		14. NAME OF HUSBAND OR WIFE <b>LILLY HERZOG</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>490-20-3977</b>		17. INFORMANT Address <b>VA HOSPITAL RECORDS, ST LOUIS, MO.</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>ASPIRATION PNEUMONIA</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CARCINOMA OF STOMACH WITH METASTASES</b>							
DUE TO (c) <b>- - 151X -</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>- - -</b>				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 checked="" type="checkbox"/> NO <input 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. <input checked="" type="checkbox"/> attended the deceased from <b>11-2-59</b> to <b>11-5-59</b> and last saw him <del>live</del> <sup>die</sup> on <b>11-5-59</b> Death occurred at <b>4:05 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>H. L. Ellis</i> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		22c. DATE SIGNED <b>11/6/59</b> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-8-59</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>Washington, Missouri.</b>			
24. FUNERAL DIRECTOR <b>Nieburg-Vitt, Washington, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 6 1959</b>		26. REGISTRAR'S SIGNATURE <i>Roal Smith M.D.</i> <b>mjb</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 6 T AGM SA

**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 Lawrence A. Gerlich

Licensed Embalmer No. 4979

P. O. Address St. Louis, Mo.

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.