

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042122

FILED VS NOV 20 1959

210429

STATE FILE NUMBER

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

UNDECEASED

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Length of stay in 1b _____ 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"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY _____ c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 2712 INDIANA Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE M. HOLTZMANN LAMB				4. DATE OF DEATH Month Day Year NOV 10 1959									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH AUG 9 1910		9. AGE (last birthday) 49		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) BOOKKEEPER				10b. KIND OF BUSINESS OR INDUSTRY CECO STEEL CO		11. BIRTHPLACE (City and state or country) TROY INDIANA		12. CITIZEN OF WHAT COUNTRY U-S-A					
13a. FATHER'S NAME JACOB HOLTZMANN				13b. MOTHER'S MAIDEN NAME IDA KUNKLER				14. NAME OF HUSBAND OR WIFE _____					
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. 489-05-9156		17. INFORMANT DOROTHY FRAZIER Address 3730 IOWA AVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver neoplasm failure DUE TO (b) Generalized atherosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 199.2										INTERVAL BETWEEN ONSET AND DEATH 3 days 9 minutes			
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. I attended the deceased from March 19 to 10 Nov 17 and last saw her alive on 10 Nov 17 Death occurred at 11:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Catanzaro M.D.</i>						22b. ADDRESS 2705 Clifton				22c. DATE SIGNED 11-12-59			
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE NOV 13 1959		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM				23d. LOCATION (City, town, or county) ST. LOUIS		(State) MO			
24. FUNERAL DIRECTOR Thomas Kutie Address 2906 Gravois				25. DATE RECD. BY LOCAL REG. NOV 12 1959		26. REGISTRAR'S SIGNATURE <i>Loal Smith M.D.</i>							

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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.