

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN - 7 1960 162

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120 '59 0 4 4 5 6 7

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY JEFFERSON			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 RURAL-MERAMEC		Length of stay in 1b 11 Mos-5 Day	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF THE NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hill Infirmary		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) HOTEL FLVERNE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EMERY Middle L. Last HOLLO			4. DATE OF DEATH Month DECEMBER Day 19 Year 1959		
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT OWNER	11. BIRTHPLACE (City and state or country) HUNGARY	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME LOUIS HOLLO		13b. MOTHER'S MAIDEN NAME ROSE CSORBA		14. NAME OF HUSBAND OR WIFE ETHEL DORKO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Bro. Roch St. Joseph's Hill Infirmary Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) PARKINSON DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS					INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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 JANUARY 14 / 59 to 10 / 29 / 59 and last saw him alive on 10 / 29 / 59 Death occurred at 12 / 19 / 59 3:30p m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert E. Bowen, M.D.			22b. ADDRESS St. Joseph's Hill Infirmary, Eureka		22c. DATE SIGNED 12/19/59
23a. HOSPITAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)		
Removal 12/22/1959	12/22/1959	Osborn Cemetery	Meramec, Mo		
24. GENERAL DIRECTOR Arthur J. Donnelly, 3840 Indele		ADDRESS	25. DATE RECD. BY LOCAL REG. 12-22-59	26. REGISTRAR'S SIGNATURE Robert E. Bowen	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

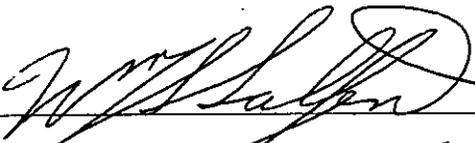
JAN 8 1968

STATEMENT BY LICENSED EMBALMER

JAN 11 1968

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  _____

Licensed Embalmer No. 4699
P. O. Address 3840 Jend

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.