

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 7 2 3

FILED VS. DEC 21 1959

211334

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis, MO</i>		Length of stay in 1b <i>4 days</i>		c. CITY OR TOWN <i>E. St. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Louis Children's Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>1725 Theodore</i>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>Gary Alan Melzer</i>			4. DATE OF DEATH Month Day Year <i>12 5 59</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>10/27/54</i>	9. AGE (last birthday) <i>5 years</i>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (City and state or country) <i>Chester, Illinois</i>		
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13a. FATHER'S NAME <i>Walter Melzer</i>		13b. MOTHER'S MAIDEN NAME <i>Dorothy Weber</i>		
14. NAME OF HUSBAND OR WIFE <i>none</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		
17. INFORMANT <i>Mary Ritter</i>		Address <i>500 So Kingshighway</i>				

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
IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Acute Cerebral Edema - 2° to Hypoxia - Etiology unknown</i> DUE TO (c) <i>Aspiration Pneumonia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>491x</i>			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.	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 *12-1-59*, to *12-5-59* and last saw ^{her}him alive on *12-5-59*
 Death occurred at *5:30 A.M.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Leonard Peter Rome M.D.</i>		22b. ADDRESS <i>500 S. Kingshighway</i>		22c. DATE SIGNED <i>12-5-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>12-5-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Steeleville, Illinois.</i>		23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR <i>Albert H. Hoppe Inc., 4700 Washington, Blvd.</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>DEC 7 1959</i>	26. REGISTRAR'S SIGNATURE <i>Harold Smith M.D.</i>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John J. Harris

Licensed Embalmer No. 4108

P. O. Address St. Louis

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.