

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003481

FILED VS JAN 22 1960

2 418

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) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>	Length of stay in 1b	c. CITY OR TOWN <b>ST.</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1710 ALLEN AVE</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH (Josip) GUSCIC</b>			4. DATE OF DEATH Month Day Year <b>JAN. 11, 1960</b>		
--	--	--	--	--	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-17-1896</b>	9. AGE (last birthday) <b>63</b>	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) <b>RETIRED LABORER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>AUSTRIA HUNGARY U-S-A</b>	12. CITIZEN OF WHAT COUNTRY
---	-----------------------------------	--	-----------------------------

13a. FATHER'S NAME <b>JOSIP GUSCIC</b>	13b. MOTHER'S MAIDEN NAME <b>MARY LUPC</b>	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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>488-03-7263</b>	17. INFORMANT <b>ANTON GUSCIC 4236 GERTRUDE</b>	Address
---	---	--	---------

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)	<b>Myocardial Infarction</b>	<b>10 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 **1/1/60** to **1/11/60** and last saw her/him alive on **1/11/60**  
Death occurred at **6:20 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Naniel S. Hellman M.D.</b>	22b. ADDRESS <b>1515 LAFAYETTE AVE</b>	22c. DATE SIGNED <b>1/11/60</b>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>DEC 13 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET BURIAL PARK</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, CO. MO</b>
---	---------------------------------	---	---

24. EMBALMER DIRECTOR <b>Thomas Kutis 2906 Gravois</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 13 1960</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith. M.D.</b>
---	--	--

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 *James C. White*

Licensed Embalmer No. 4347

P. O. Address 2906 Dr.

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.