

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-003485

FILED VS JAN 15 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **28** STATE FILE NUMBER

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 St. Louis		Length of stay in 1b	c. CITY OR TOWN Venice, Ill	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 500 Jefferson Str		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MOLLIE Middle HAASE Last			4. DATE OF DEATH Month Jan Day 2 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-28-1896	9. AGE (last birthday) 83	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) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY U. S. A
13a. FATHER'S NAME Mike Resch		13b. MOTHER'S MAIDEN NAME Johanna		14. NAME OF HUSBAND OR WIFE Deceased		
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. None		17. INFORMANT Address Clarence Mueller - 500 Jefferson Str Venice Ill		

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) Generalized Carcinomatosis				22 Wks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (b) Generalized Weakness	
				DUE TO (c) Generalized Cachexia	
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 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.) 199.2			
20c. TIME OF INJURY Hour 7 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 5:00 3/18/1958 to 2 Jan 60 and last saw her live on 2 Jan 60 Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Leonard A. P. Stem M.D.		22b. ADDRESS 1918 East Grand Blvd		22c. DATE SIGNED 2 Jan 60	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE Jan 5-1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo		
24. FUNERAL DIRECTOR ADDRESS Edw. Johnson - 2516 E. 14th		25. DATE RECD. BY LOCAL REG. JAN 4 1960	26. REGISTRAR'S SIGNATURE Coart Smith. M.D.		

M. J. 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 Herbert J. Lee Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22

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.