

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

KC-1988770 SL 21819

FILED VS. JAN 29 1960

60-003681  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 623**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>	Length of stay in 1b <b>25 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VAH 915 N GRAND ST LOUIS MO</b>		d. STREET ADDRESS (If outside, give location) <b>3517 CHIPPEWA</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>E.</b> Last <b>KURTZ</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>16</b> Year <b>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>3/3/92</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PAINTING</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>JACOB KURTZ</b>		13b. MOTHER'S MAIDEN NAME <b>MARY HAMMERSCHMIDT</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>A498-10-5153</b>	17. INFORMANT Address <b>FLORA GUND 4938 LINDENWOOD ST LOUIS MO.</b>		

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 <b>UNKNOWN</b>
IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	<b>491x</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>SEVERE MACROCYTIC ANEMIA WITH VASCULAR PURPURA</b>		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	
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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 _____ Month, Day, Year _____ 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 <b>VA</b> <b>12/22/59</b> to <b>1/16/60</b> and last saw him <sup>from</sup> <b>1/16/60</b> Death occurred at <b>6:55 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Deceased or title) <b>RABAEI CORREIA COBOLIS M.D.</b>		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		22c. DATE SIGNED <b>1/17/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE <b>JAN. 18, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MISSOURI CREMATORY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>KRIEGSHAUSER 4228 S. KINGS HIGHWAY</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 17 1960</b>	26. REGISTRAR'S SIGNATURE <b>Lois Smith, M.D.</b> <i>msb</i>	

DOCUMENT

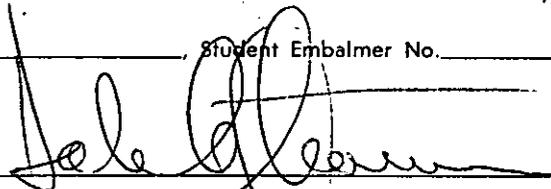
MEDICAL CERTIFICATION

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

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.