

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 5 1960

-60-003897

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 762** STATE FILE NUMBER **1**

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in 1b 6 days | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4201a Clay Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) First Margaret Middle L Last Palya MARGARET L. PALYA | | | 4. DATE OF DEATH Month JANUARY Day 20 Year 1960 | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3-10-1911 | 9. AGE (last birthday) 48 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady - Asst Buyer | | 10b. KIND OF BUSINESS OR INDUSTRY Stix-Baer-Fuller | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A | |
| 13a. FATHER'S NAME Robert Frahm | | 13b. MOTHER'S MAIDEN NAME Laura Wilburn | | 14. NAME OF HUSBAND OR WIFE George R. Palya | |
| 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. | 17. INFORMANT Address George R. Palya, 4201a Clay Avenue | | |

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| 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) POST-OPERATIVE HYPOTENSION | | 6 HOURS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) | DUE TO (b) HIATUS HERNIA | 6 MONTHS |
| | DUE TO (c) 560.4 | |

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| 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 | |
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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 _____ s.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 **JAN. 15, 1960** to **JAN. 20, 1960** and last saw her/him alive on **JAN. 20, 1960**
Death occurred at **7:25 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>C. O. Vanillan, M.D.</i> (Degree or title) M. D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 1/21/60 |
|---|--|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Jan 23 1960 | 23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery | 23d. LOCATION (City, town, or county) St. Louis Missouri |
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| 24. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair Av | 25. DATE RECD. BY LOCAL REG. JAN 22 1960 | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> m d s |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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 Helford & Beumle

Licensed Embalmer No. 4282

P. O. Address Howe

NOTE: This form 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.