

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 17 1960 / 62

60-006935

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 5595 Registrar's No. 11

INDEXED

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIMMSWICK</u> Length of stay in 1b <u>6 mos</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FOUR OAKS NUR HOME</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>MATTESE</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>Rt-8 -</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IGNATIUS</u> Middle <u>JOHN</u> Last <u>HOLTZMAN</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>6</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-13-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>24</u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>GERMANY</u>			
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
13c. NAME OF HUSBAND OR WIFE <u>SUSIE HOLTZMAN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>JOHN HOLTZMAN</u> Address <u>Rt 8 - Box 1798 MEHLVILLE 29 Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, massive</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>A.S. Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>					
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 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 <u>1956</u> to <u>date</u> and last saw ^{her} him alive on <u>2/1/60</u> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Frank Huck M.D.</u>			22b. ADDRESS <u>Fector, Mo.</u>		22c. DATE SIGNED <u>2/6/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>FEB 8, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ASSUMPTION Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>MATTESE Mo</u>		
24. FUNERAL DIRECTOR <u>Fey Funeral Home</u> ADDRESS <u>MEHLVILLE Mo</u>			25. DATE RECD. BY LOCAL REG. <u>2-8-60</u>		26. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 23 1960

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. Gan Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood

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.