JRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS FEB 25 1960

-60-008370

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1195

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b: DOA
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: City Hospt.
Inside Limits: Yes XX No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St.Louis
c. CITY OR TOWN: University City
Inside Limits: Yes XX No ☐
d. STREET ADDRESS (If outside, give location): 1320 Sheridan Dr.
Reside on Farm: Yes ☐ No XX

3. NAME OF DECEASED (Type or print): First: Albert Middle: H Last: Holt
4. DATE OF DEATH: Month 2 Day 1 Year 60
5. SEX: Male
6. COLOR OR RACE: White
7. Married XX Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4-2-1888
9. AGE (last birthday): 71
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): Draftman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St.Chas.Co.Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Emil Holt
13b. MOTHER'S MAIDEN NAME: Lucy Niemeyer
14. NAME OF HUSBAND OR WIFE: Florence Holt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): **********
16. SOCIAL SECURITY NO.: UNK
17. INFORMANT: Florence Holt Address: 1320 Sheridan Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c) Angina Pectoris 420.1
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO XX
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3-8-58, to 2-1-60 and last saw ~~her~~ him alive on 2-1-60
Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: L. N. Grod (Degree or title): D.O.
22b. ADDRESS: 8367 Olive St. Rd.
22c. DATE SIGNED: 2-2-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-4-60
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis Mo.

24. FUNERAL DIRECTOR: J.W.Clark F.H. ADDRESS: 1125 Hodiamont Ave.
25. DATE REC'D. BY LOCAL REG.: FEB 2 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. P.O.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

ENDED

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.