JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS FEB 23 1960

-60-008485

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1769

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DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO.

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #1.

Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY

c. CITY OR TOWN: St.Louis

Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 3127 Locust St.

Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First IBA. Middle Last KUBICEK

4. DATE OF DEATH: Month FEBRUARY Day 11, Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 6/1/1879

9. AGE (last birthday): 80

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): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Homes

11. BIRTHPLACE (City and state or country): Austria

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Unavailable

13b. MOTHER'S MAIDEN NAME: Unavailable

14. NAME OF HUSBAND OR WIFE: None

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.: Unknown

17. INFORMANT: Oscar G.Schaeffer, Address: Pub.Adm.,St.Louis,Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 491+

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Arteriosclerotic Heart Disease

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 2-4-60, to 2-11-60 and last saw her/him alive on 2-11-60

Death occurred at 3:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert J. Stern, M.D. (Degree or title)

22b. ADDRESS 1515 LAFAYETTE AVE.

22c. DATE SIGNED 2-11-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE 2-17-60

23c. NAME OF CEMETERY OR CREMATORY New Pickers Cemetery

23d. LOCATION (City, town, or county) (State): St.Louis,Mo.

24. FUNERAL DIRECTOR ADDRESS: Albert H.Hoppe,Inc.,4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG. FEB 15 1960

26. REGISTRAR'S SIGNATURE Karl Smith, M.D. MD

(Licensed Embalmer's Statement on Reverse Side)

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 Melvin L Kemp

Signature of Student Embalmer

Licensed Embalmer No. 4 0 5

P. O. Address 4911 Wa

St Louis M

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