

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012320

FILED VS APR 4 1960

2 3357

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>2 mo. 2 1/2 wks</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6005 O'Dell</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle <b>Balz</b> Last <b>Balz</b>	4. DATE OF DEATH Month <b>3</b> Day <b>22</b> Year <b>60</b>
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5. SEX <b>Female</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>5-17-1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Leonard BALZ</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie SIEBER</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS. H. D. SCHILLING 6005 ODELL</b> Address
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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: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 mo.</b>
DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Intertrochanteric Fracture Left Femur</b>	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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Patient found on floor in hall. Brain</b>
20c. TIME OF INJURY Hour <b>5:45</b> p.m. Month, Day, Year <b>11/5/60</b>	in <b>left hip.</b>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>St. Louis Chronic Hosp.</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>Mo.</b>	STATE <b>Mo.</b>
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21. I attended the deceased from **1-4-60** to **3-22-60** and last saw her alive on \_\_\_\_\_  
Death occurred at **9:40 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>	22b. ADDRESS <b>5800 Arsenal</b>	22c. DATE SIGNED <b>3/23/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>3-26-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY MO</b>
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24. FUNERAL DIRECTOR <b>HOWARD H. MICHEL 5980 SOUTHWEST</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 24 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*O.K. Paul J. Smith Deputy Coroner 4/1/60*

*7013*

**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. Law Jr.

Licensed Embalmer No. 4800

P. O. Address Kipwauke

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