

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. APR 22 1960

=60-016961

STATE FILE NUMBER

2 3701

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 weeks	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 Christian Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6312 Laura Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Louis J. Middle Huszar, Sr.		4. DATE OF DEATH Month March Day 31 Year 1960	
Louis J Huszar			

5. SEX male	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 5-5-1899	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--------------------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed	10b. INDUSTRY OF BUSINESS OR INDUSTRY Auto Radiator Service	11. BIRTHPLACE (City and state or country) Hungary	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	--	--

13a. FATHER'S NAME Joseph Huszar	13b. MOTHER'S MAIDEN NAME Clara Sebo	14. NAME OF HUSBAND OR WIFE Mary Huszar
--	--	---

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 Mrs. Mary Huszar, 6312 Laura Avenue
---	---------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Congestive Heart failure	
	DUE TO (c) 42 0 0	

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"/> N- <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 _____ 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 March 18, 1960 to March 31, 1960 and last saw him alive on March 31, 1960 Death occurred at 5:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Julius Elton M.D. (Degree or title)	22b. ADDRESS 607 N. Grand St. Louis Mo	22c. DATE SIGNED 4/14/60 (State)
--	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE April 4, 1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Missouri
---	-----------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Av	25. DATE RECD BY LOCAL REG. APR 17 1960	26. REGISTRAR'S SIGNATURE Coal Smith, M.D.
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1070

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 *Selement McQuay*

Licensed Embalmer No. 3732

P. O. Address *H. Harris*

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.