

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017538

FILED VS APR 22 1960

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1201 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>	Length of stay in lb <u>5 yrs</u>	c. CITY OR TOWN <u>KIRKWOOD</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1100 Ann Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1100 ANN AVE.</u>

3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>M.</u> Last <u>LIMBOCKER</u>			4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/1898</u>	9. AGE (last birthday) <u>61</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Cherokovakia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>MICHAEL Matusek</u>			13b. MOTHER'S MAIDEN NAME <u>JOSEPHINE REHAK</u>		14. NAME OF HUSBAND OR WIFE <u>Wayne E. Limbocker</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>349-28-7242</u>	17. INFORMANT <u>Wayne E. Limbocker, 1100 Ann Ave.</u>		
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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) <u>Carcinoma, right breast, with generalized metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)			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 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 <u>10¹²</u> Month, Day, Year <u>Aug 29, 1959</u>					
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 Aug 29, 1959 to April 10, 1960 and last saw her alive on April 10, 1960
Death occurred at 10¹² P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>James B. Jones M.D.</u>		22b. ADDRESS <u>9213 Manchester Rd. Park Hill 19 Mo</u>		22c. DATE SIGNED <u>4-11-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4/11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. GREENWOOD LOCAL</u>	23d. LOCATION (City, town, or county) (State) <u>Chicago, Ill.</u>		
24. FUNERAL DIRECTOR <u>Pfitzinger Mortuary, Kirkwood, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>4-12-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Benjamin

Licensed Embalmer No. *436*
P. O. Address *St. Louis*

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.