

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021009

FILED VS. MAY 25 1960

318

1003

4668

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3169 OHIO AVE		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First SOPHIE Middle HANTACK Last				4. DATE OF DEATH Month MAY Day 2 Year 1960											
5. SEX FEMALE		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 JUNE 9, 1886		9. AGE (last birthday) 73		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) HOUSE WORK				10b. KIND OF BUSINESS OR INDUSTRY AT HOME				11. BIRTHPLACE (City and state or country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY U-S-A					
13a. FATHER'S NAME PETER HOPP				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE WILLIAM HANTACK							
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. NONE		17. INFORMANT Address HARVEY HANTACK 3169 OHIO AVE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Left Hip DUE TO (b) Myocardial Infarction DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										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 (e) 904.91										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) Suffered in fall to floor											
20c. TIME OF INJURY Hour a.m. p.m. 4 10 60		Month, Day, Year April 10, 1960		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.) 24 Home		20f. CITY, TOWN, OR LOCATION St Louis		COUNTY MO		STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____. Death occurred at _____ 945 A m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE Paul J. Simon				22b. ADDRESS 1300 Clark				22c. DATE SIGNED 5/3/60							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE MAY 5 1960		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.				23d. LOCATION (City, town, or county) ST. LOUIS		23e. STATE MO					
24. GENERAL DIRECTOR Thomas Kutis 2906 Gravois				25. DATE RECD. BY LOCAL REG. MAY 3 1960		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.									

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 James C. White

Licensed Embalmer No. 4347
P. O. Address 2906

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.