

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 18 1960

318

1003

4970-60-021074

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 <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONY Hosp</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5635 OLEATHA</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>SUZANNA</u> First <u>HOLZINGER</u> Middle Last			4. DATE OF DEATH <u>MAY 10 1960</u> Month Day Year		
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>JUNE 4 1894</u>	9. AGE (last birthday) <u>65</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>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		11. BIRTHPLACE (City and state or country) <u>AUSTRIA HUNGARY U-S-A</u>	
12a. FATHER'S NAME <u>MICHAEL WILD</u>		13b. MOTHER'S MAIDEN NAME <u>BARBARA WYANT</u>		14. NAME OF HUSBAND OR WIFE <u>JOSEPH HOLZINGER</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>NONE</u>		17. INFORMANT Address <u>TERESA FRICK 5635 OLEATHA</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>			<u>1 yr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of the Left Breast</u>		<u>3 yrs</u>
	DUE TO (c) <u>170x</u>		

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"/> N <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 Month, Day, Year a.m. p.m.			
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 2/5/57 to 5/10/60 and last saw her/him alive on 5/9/60
 Death occurred at 4:00 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>D. Benjamin</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>7430 Virginia Avenue</u>	22c. DATE SIGNED <u>5/10/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>MAY 12 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST. MARCUS</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
24. FUNERAL DIRECTOR <u>Thomas Kates 2906 Grand</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAY 11 1960</u>	REGISTRAR'S SIGNATURE <u>Roan Smith. M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

777

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. Will

Licensed Embalmer No. 4347

P.O. Address 2906 ...

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.