

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021803

FILED VS MAY 31 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1615 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>CLAYTON</u>		Length of stay in 1b	c. CITY OR TOWN <u>Pagedale</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>St Louis County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1324 Penney Lannaia</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MANDIC</u> Last <u>MANDIC</u>			4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</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>12/2/80</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Zangarlaw</u>		12. CITIZEN OF WHAT COUNTRY <u>yes</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Mandic</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT <u>Mary Mandic 1324 Pennsylvania</u>		

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>Myocardial infarction suspected</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>years</u> <u>year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u> <u>years</u> <u>year</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"/> No <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 <u>3:45</u> a.m. p.m.	Month, Day, Year <u>5-19-1960</u>	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.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 5-19-1960 to 5-19-1960 and last saw him alive on 5-19-1960
Death occurred at 3:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ronald C. Pasmore M.D.</u> (Degree or title)		22b. ADDRESS <u>601 S. Brentwood Blvd.</u>		22c. DATE SIGNED <u>5-19-60</u>
23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>REMOVAL</u>	23b. DATE <u>5/23/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>	

24. FUNERAL DIRECTOR <u>John Dwyer</u> ADDRESS <u>5541 Riverview</u>		25. DATE RECD. BY LOCAL REG. <u>5-20-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy</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

JW Rister

Licensed Embalmer No. 3980

P. O. Address St Louis Mo

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.