

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 22 1960

60-029251

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1998

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>ST LOUIS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	c. CITY OR TOWN <b>ST LOUIS Co</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MILLER NURSING Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8221 McKENZIE RD</b>	
3. NAME OF DECEASED (Type or print) <b>MATTHEW KUATERNIK-QUATERNIK</b>			4. DATE OF DEATH <b>JUNE 29 1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 3 1875</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (City and state or country) <b>AUSTRIA HUNGARY</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>JACOB QUATERNIK</b>		13b. MOTHER'S MAIDEN NAME <b>BARBARA ROSEMOND</b>		14. NAME OF HUSBAND OR WIFE <b>THERESA QUATERNIK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-18-8014</b>	17. INFORMANT <b>VICTOR QUATERNIK</b> Address <b>8221 McKENZIE RD</b>		
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) <b>Acute Cardiac dilatation</b>					<b>1 day.</b>
DUE TO (b) <b>Chr. Myocarditis</b>					<b>4 yrs.</b>
DUE TO (c) <b>Arricular fibrillation</b>					<b>8 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arterio Sclerosis - senility</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.) <b>none</b>			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year <b>none</b>				
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.) <b>none</b>	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>September 12, 1959</b> to <b>June 29, 1960</b> and last saw her/him alive on <b>June 10, 1960</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Geo. Chamberlain MD</b>			22b. ADDRESS <b>767 Garrison Ave</b>		22c. DATE SIGNED <b>10-27-60</b>
23a. BURIAL, CREMATION, or other disposition	23b. DATE <b>JULY 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>	
24. FUNERAL DIRECTOR <b>Thomas Lutes 2906 Davis</b>		25. DATE RECD. BY LOCAL REG. <b>7-1-60</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>		

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. Bell*

Licensed Embalmer No. 4347

P. O. Address 2906 Du

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c  
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.