

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032351

FILED VS. AUG 26 1960

318

1003

7575

STATE FILE NUMBER

ENDED

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 <i>Missouri</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital</i>		d. STREET ADDRESS (If outside, give location) <i>2313rd Cass Ave</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles Holubeck</i>			4. DATE OF DEATH Month Day Year <i>7-29-1960</i>		
---	--	--	--	--	--

5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>1-10-1878</i>	9. AGE (last birthday) <i>82</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter (retired)</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Vandervoorts</i>	11. BIRTHPLACE (City and state or country) <i>ST. LOUIS MO</i>	12. CITIZEN OF WHAT COUNTRY <i>USA.</i>
--	--	---	--

13a. FATHER'S NAME <i>Jos Holubeck</i>	13b. MOTHER'S MAIDEN NAME <i>Pauline Klimt</i>	14. NAME OF HUSBAND OR WIFE <i>FRANCES</i>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Esther Seiler 2313rd Cass Ave</i>
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Right Hip</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Generalized Arteriosclerosis</i>	
	DUE TO (c) <i>904.0 -21</i>	

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 type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <i>Suffered in fall in house</i>
--	--	--

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <i>6 2360a or about June 23rd 1960</i>
--

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.) <i>20 Home</i>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St Louis MO</i>
--	--	---

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name of physician) <i>Charles M. Green</i>	22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>8-1-60</i>
---	-----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>8-1-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS MO</i>
--	----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <i>A. Kraus 2707 N Grand</i>	25. DATE RECD. BY LOCAL REG. <i>AUG 1 1960</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
--	---	--

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 W E Morris

Licensed Embalmer No. 3360
P. O. Address St Louis

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.