

as record
 to Generalized Arteriosclerosis
 Letter from Dr.
 as record
 to Generalized Arteriosclerosis
 due to Generalized Arteriosclerosis
 BY AFFIDAVIT OF LI. E. R. Lerwick M.D. DOCUMENT

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY EFF.		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b 6 WEEKS	c. CITY OR TOWN FESTUS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. BAPTIST HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS R#2 (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ANTHONY <i>Anthony</i> Middle KNOBLOCH <i>Knobloch</i>			4. DATE OF DEATH Month Day Year SEPT 8 1960		
5. SEX MALE	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 2-21-1893	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY P.P.E. CO.	11. BIRTHPLACE (City and state or country) PRAGUE, CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		13c. NAME OF HUSBAND OR WIFE BESSEE	
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.		17. INFORMANT MRS. A. A. KNOBLOCH FESTUS, MO. Address	
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>Coronary occlusion, left</i> <i>Coronary arteriosclerosis</i> DUE TO (b) <i>Phlebotomy on 9/8/60</i> <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Arteriosclerosis</i>					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 (a) 4201					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 checked="" type="checkbox"/> NO <input 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 <i>1956</i> to <i>9/8/60</i> and last saw him alive on <i>9/8/60</i> . Death occurred at <i>2:45pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>E. R. Lerwick M.D.</i> (Degree or title)			22b. ADDRESS <i>453 N. Taylor</i>		22c. DATE SIGNED <i>9/8/60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-12-60	23c. NAME OF CEMETERY OR CREMATORY CATHOLIC		23d. LOCATION (City, town, or county) CRYSTAL CITY, MO. (State)	
24. FUNERAL DIRECTOR GENTRY R. POLITTE CRYSTAL CITY MO		ADDRESS	25. DATE RECD. BY LOCAL REG. SEP 9 1960	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>	

MEDICAL CERTIFICATION

1960

SEP 23 1960

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 *Geoffrey R. Pollock*

Licensed Embalmer No. 348

P. O. Address Crystal

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.