URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10272 STATE FILE NUMBER -60-039987

NDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Lutheran Hospital — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis

c. CITY OR TOWN: Lemay — Inside Limits: Yes ☑ No ☐

d. STREET ADDRESS (If outside, give location): 3241 Lemay Ferry Rd — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Rose Middle: Last: Masek

4. DATE OF DEATH: Month: October Day: 20 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2/17/16

9. AGE (last birthday): 44 — 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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (City and state or country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY: U S

13a. FATHER'S NAME: William Fiala

13b. MOTHER'S MAIDEN NAME: Rose ?

14. NAME OF HUSBAND OR WIFE: William

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: William Masek Address: 3241 Lemay Ferry Rd

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Portal Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 581.0

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1958, to 10/20/60 and last saw her alive on 10/20/60
Death occurred at 9:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. J. Schmiemeier MD

22b. ADDRESS: 6817 Scovos St Louis

22c. DATE SIGNED: 10/21/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 10/24/60

23c. NAME OF CEMETERY OR CREMATORY: New St Marcus Cemetery

23d. LOCATION (City, town, or county) (State): St Louis County Mo.

24. FUNERAL DIRECTOR ADDRESS: Moydell Funeral Home 1926 Allen

25. DATE RECD. BY LOCAL REG.: OCT 24 1960

26. REGISTRAR'S SIGNATURE: Earl Smith. M.D.

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 b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Hadley F. Haeller Jr

Licensed Embalmer No. 495C

P. O. Address St Louis

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.