

Quinlan: S. G. of fictitious - Small - not to be used  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

|  |                                  |  |   |   |  |   |  |
|--|----------------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>  |                                  |  |   | Length of stay in 1b  |  | c. CITY OR TOWN <b>St. Louis</b>  |  |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>   |                                  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | d. STREET ADDRESS (If outside, give location)<br><b>4626 Shenandoah Ave.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANGELA</b> Middle <b>F.</b> Last <b>HARTZBURGE</b>   |                                  |  |   | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>21</b> Year <b>1960</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-28-1897</b>                | 9. AGE (last birthday)<br><b>63</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Lima, Ohio</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME<br><b>Otmar J. Feltz</b>  |                                  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Susan F. Mooney</b> |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Everett E. Hartzburge</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>490-22-7678</b>  |   | 17. INFORMANT Address<br><b>Everett E. Hartzburge 4626 Shenandoah Ave.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Peritonitis; Chronic Myocarditis</b><br><b>Acute Pancreatitis; Interstitial Nephritis</b><br><b>Cardiac Arrest, while under going operation (fistula) at De Paul Hospital, on November 21st, 1960</b> |                                  |  |   |   |  | 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)  |                                  |  |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><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 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.)<br><b>578x</b><br><b>see above</b> |  |   |  |
| 20c. TIME OF INJURY<br><b>12:10</b> Hour a.m. p.m.<br>Month, Day, Year <b>11-21-60</b>   |                                  | 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.)<br><b>at Hospital</b>                  |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE<br><b>St Louis Mo</b>   |  |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at _____ <b>12:10 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |                                  |  |   |   |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Joseph M. Zura Deputy Coroner</b>   |                                  |  |   | 22b. ADDRESS<br><b>1300 Clark</b>   |  | 22c. DATE SIGNED<br><b>11-22-60</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal (Rail)</b>   |                                  | 23b. DATE<br><b>11-24-1960</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Vincennes, Indiana</b>  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Kriegshauser 4228 S. Kingshighway Blvd.</b>   |                                  |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>NOV 22 1960</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b>  |  |

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Edwin A. McKeever

Licensed Embalmer No. 3024

P. O. Address \_\_\_\_\_

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