

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2910 OSAGE ST</u>		d. STREET ADDRESS (If outside, give location) <u>2910 OSAGE ST</u>	

3. NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>OTEC</u> Last			4. DATE OF DEATH Month <u>NOV</u> Day <u>30</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 29 1872</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>BOHEMIA U-S-A</u>	
13a. FATHER'S NAME <u>JOSEPH TUMA</u>		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <u>FRANK OTEC (DECD)</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>BARBARA REZNICK 2910 OSAGE</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
DUE TO (b) <u>Ch. Myocarditis</u>		<u>2 yrs.</u>
DUE TO (c) <u>Auricular fibrillation</u>		<u>8 days</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arterio sclerosis - senility</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.) <u>None 433.1</u>
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>None</u>	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
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21. I attended the deceased from <u>June 8-1954</u> to <u>Nov. 30-1960</u> and last saw her/him alive on <u>Nov. 29-1960</u> Death occurred at <u>6 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Geo Calanach, M.D.</u>	(Degree or title)	22b. ADDRESS <u>7767 Gravois Ave</u>	22c. DATE SIGNED <u>12-2-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC 3, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST PETER + PAUL</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO.</u>
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24. GENERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 2 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

230-530

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *James C. Hill*

Licensed Embalmer No. 434
P. O. Address 2906

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