

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044459

FILED VS. NOV 28 1960 317

Primary Registration District No. 544 Registrar's No. 3318

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood Mo.		Length of stay in 1b 2 days		c. CITY OR TOWN Fenton Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 505 Main St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Patrecia Middle Eulah Last Hitzert				4. DATE OF DEATH Month 11 Day 13 Year 60									
5. SEX Female		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 6/19/1909		9. AGE (last birthday) 51		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) Manager-Owner			10b. KIND OF BUSINESS OR INDUSTRY Restaurant			11. BIRTHPLACE (City and state or country) Arlington Mo.			12. CITIZEN OF WHAT COUNTRY U. S. A.				
13a. FATHER'S NAME Ivan Allen				13b. MOTHER'S MAIDEN NAME Effie Mallone				14. NAME OF HUSBAND OR WIFE Garrett Hitzert					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. _____				17. INFORMANT Garrett Hitzert Address 505 Main St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage										INTERVAL BETWEEN ONSET AND DEATH 18 hr			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arterial Sclerosis										1 yr			
DUE TO (c) Hypertension & Cerebral Vasculature										1 yr			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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.)									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from 11/12/60 to 11/13/60 and last saw her alive on 11/13/60 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Charles Burnside M.D. (Degree or title)				22b. ADDRESS 206 W. High St. Springfield, Mo.				22c. DATE SIGNED 11/15/60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/16/60		23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery				23d. LOCATION (City, town, or county) Fenton Mo.					
24. FUNERAL DIRECTOR Leaff Fiser ADDRESS Fenton Mo.				25. DATE RECD. BY LOCAL REG. 11-15-60				26. REGISTRAR'S SIGNATURE John E. Murphy 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Samuel J. [Signature]

Licensed Embalmer No. [Signature]

P. O. Address [Signature]

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.