

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Mo</u>			Length of stay in 1b		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5943 CLIFTON</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5943 CLIFTON</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle Last <u>VARGO</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19 1882</u>	9. AGE (last birthday) <u>78</u>	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) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>J. W. LOSSE</u>		11. BIRTHPLACE (City and state or country) <u>BOHEMIA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13a. FATHER'S NAME <u>JOHN DRAZAN</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>ANDREW VARGO</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>-</u>		17. INFORMANT Address <u>ANDREW VARGO 5943 CLIFTON</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)			<u>CEREBRAL THROMBOSIS</u>				<u>3 Days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>				<u>5 yrs</u>
			DUE TO (c) <u>332x</u>				
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 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 <u>1959</u> to <u>JAN 4, 1961</u> and last saw her ^{her} _{him} alive on <u>JAN 2, 1961</u> Death occurred at <u>4:15pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John A. Carner M.D.</u> (Degree or title)				22b. ADDRESS <u>4401 Hampton ST. Louis 9, Mo</u>		22c. DATE SIGNED <u>1-6-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JAN. 7 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW PICKER CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kates 2906 Gravier</u>			25. DATE RECD. BY LOCAL REG. <u>JAN 6 1961</u>		26. REGISTRAR'S SIGNATURE <u>Lead Smith M.D.</u>		

STATEMENT BY LICENSED EMBALMER

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

Student _____

Signature of Student Embalmer

Signed

Eleanore Province

Licensed Embalmer No. *3403*

P. O. Address *2906 Gavour*

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.