

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

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 Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 day	c. CITY OR TOWN Kirkwood
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 418 W. Argonne
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WITTICH		4. DATE OF DEATH Month Day Year Jan. 29, 1961	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Donald J. Wittich	
13b. MOTHER'S MAIDEN NAME Arlene Forst		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT Kirkwood 22 Address Mo. Donald J. Wittich-418 W. Argonne
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>Cerebral Anoxia</u> DUE TO (b) <u>Asphyxial</u> DUE TO (c) <u>Acute myocardial</u>			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) <u>750x</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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>1-29-61</u> to <u>1-29-61</u> and last saw <u>him</u> alive on <u>1-29-61</u> Death occurred at <u>12th</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Joseph M. Smith MD</u> (Degree or title)		22b. ADDRESS <u>950 Francis Pl</u>	22c. DATE SIGNED <u>1-30-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-31-1961	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)
24. FUNERAL DIRECTOR Pfitzinger Mort-Kirkwood 22, Mo.		25. DATE RECD. BY LOCAL REG. JAN 30 1961	26. REGISTRAR'S SIGNATURE <u>Joan Smith M.D.</u>

[Handwritten signature]

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 *[Handwritten signature]*
Licensed Embalmer No. _____

P. O. Address _____

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.