

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-003987

FILED VS JAN 16 1961

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 13

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |  |   |   |  |  |
|---|---|--|---|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>ST LOUIS</u><br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKWOOD</u> Length of stay in lb<br>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u><br>c. CITY OR TOWN <u>VALLEY PARK</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/><br>d. STREET ADDRESS (If outside, give location) <u>47 PETTYS HILL</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>JOSEPHINE</u> Middle <u>MARY</u> Last <u>WEISS</u>  |   |  | <b>4. DATE OF DEATH</b> Month <u>JAN</u> Day <u>1</u> Year <u>1961</u>  |   |  |  |
| <b>5. SEX</b><br><u>FEMALE</u>  | <b>6. COLOR, OR RACE</b><br><u>WHITE</u>  | <b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>AUG 20, 1895</u>  | <b>9. AGE (last birthday)</b><br><u>65</u>  | <b>IF UNDER 1 YEAR</b> Months Days Hours Min.<br><b>IF UNDER 24 HR</b> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>HOUSE WIFE</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>HOME</u>  |   | <b>11. BIRTHPLACE</b> (City and state or country)<br><u>MISSOURI</u>  | <b>12. CITIZEN OF WHAT COUNTRY</b><br><u>U-S-A</u>                     |  |
| <b>13a. FATHER'S NAME</b><br><u>FRANK KOLES</u>   |   |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><u>MARY DVORAK</u>  |   | <b>14. NAME OF HUSBAND OR WIFE</b><br><u>WILLIAM WEISS</u>             |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |   | <b>16. SOCIAL SECURITY NO.</b><br><u>NONE</u>  | <b>17. INFORMANT</b> Address<br><u>WILLIAM WEISS 47 PETTYS HILL</u>   |   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)   |   |  |   |   | 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 |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | <b>20a. ACCIDENT</b> <input type="checkbox"/>   | <b>SUICIDE</b> <input type="checkbox"/>  | <b>HOMICIDE</b> <input type="checkbox"/>  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)   |  |  |
| <b>20c. TIME OF INJURY</b> Hour a.m. p.m.   | <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  | <b>20f. CITY, TOWN, OR LOCATION</b>   | <b>COUNTY</b>   | <b>STATE</b>   |  |
| <b>21. I attended the deceased from</b> <u>Sept 20, 1960</u> to <u>Jan 1, 1961</u> and last saw her alive on <u>Dec 31, 1960</u><br>Death occurred at <u>235 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |  |   |   |  |  |
| <b>22a. SIGNATURE</b> (Degree or title)<br><u>Charles E. Hogan, M.D.</u>  |   |  | <b>22b. ADDRESS</b><br><u>135 W. Adams Ave, Kirkwood 22 Mo</u>  |   | <b>22c. DATE SIGNED</b><br><u>Jan 3, 1961</u>                          |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>REMOVAL</u>  | <b>23b. DATE</b><br><u>JAN 4, 1961</u>  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>ST. PETER + PAUL CEM</u>   | <b>23d. LOCATION</b> (City, town, or county)<br><u>ST. LOUIS</u>  | <b>STATE</b><br><u>MO.</u>  |  |  |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><u>Thomas Xutis 2906 Gravois</u>   |   | <b>25. DATE RECD. BY LOCAL REG.</b><br><u>1-3-61</u>   | <b>26. REGISTRAR'S SIGNATURE</b><br><u>John C. Murphy, M.D.</u>   |   |  |  |

135 W Cilbana  
11-4 Tue  
105-3868

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Prado

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.