

318

1003

-61-011186

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

2338

STATE FILE NUMBER

FILED MAR 23 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Charles		c. CITY OR TOWN O'Fallon Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hosp.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS R.R. #1 (If outside, give location)			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Clara Middle Last Loveland			4. DATE OF DEATH Month 3 Day 9 Year 1961		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 8-5-1901	9. AGE (last birthday) 59	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) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Wisconsin		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Thomas Chesnowski			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Hughes Loveland						
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 Address Hughes Loveland R.R.#1 O'Fallon Mo							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of myocardium arteriosclerotic coronary thrombosis DUPLICATE TO (b) Arteriosclerotic Coronary Thrombosis DUPLICATE TO (c) 4201 INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days												
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 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 3-3-61 to 3-8-61 and last saw her ^{her} alive on 3-7-61 Death occurred at 5:25 am 5:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE Sylvester A. Flotte (Degree or title) M.D.					22b. ADDRESS 8700 Riverview			22c. DATE SIGNED 3/10/61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-13-1961		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) Lillian-Lucas Hunt Rd Mo			(State)			
24. FUNERAL DIRECTOR Ziegenhein Brothers 6409 Gravois				25. DATE RECD. BY LOCAL REG. MAR 10 1961		25. REGISTRAR'S SIGNATURE Loan Smith, M.D.						

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 Yan M. Szymore
 Licensed Embalmer No. 4343
 P. O. Address St. Louis Mo

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.