SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-011688
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3254 32-54

FILED APR 14 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN St. Louis Co. (36)
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 10504 Duke Dr.
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: CECILIA Middle: TOBIASZ Last:
4. DATE OF DEATH Month: Apr. Day: 4 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3/10/1903
9. AGE (last birthday): 58
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): Laboratory Assistant
10b. KIND OF BUSINESS OR INDUSTRY: City Hospital
11. BIRTHPLACE (City and state or country): St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Edward A. Hogan
13b. MOTHER'S MAIDEN NAME: Molly Darmandy
14. NAME OF HUSBAND OR WIFE: Joseph F. Tobiasz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph F. Tobiasz Address: 10504 Duke Dr.

MEDICAL CERTIFICATION

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 Anoxia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Insufficiency
DUE TO (c) Cardiac Ischemia (Left Block.)
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) 420.1
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3/17/61, to 4/4/61 and last saw her/him alive on 4/4/61
Death occurred at 11:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carl Wilson D.O.
22b. ADDRESS 2359 Chamberlain Rd
22c. DATE SIGNED 4/6/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/7/1961
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Mo.
24. FUNERAL DIRECTOR: John Styger & Son ADDRESS: 5541 Riverview Blvd
25. DATE RECD. BY LOCAL REG.: APR 6 1961
26. REGISTRAR'S SIGNATURE: Noal Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | 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 by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed J M Ristin

Licensed Embalmer No. 3980

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.