

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

7755-61-031059  
STATE FILE NUMBER

AMENDED

Registration District No. **AC 1218385** Primary Registration District No. **SL 427** Registrar's No. **1003**

**FILED AUG 28 1961 318**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b <b>11 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VAH, ST. LOUIS, MO.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4649 LOGBOROUGH</b>	
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>PAUL</b> Last <b>RETZ</b>			4. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>61</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/87</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN RY. EXPRESS</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOESPH RETZ</b>		13b. MOTHER'S MAIDEN NAME <b>ANNIE THEOBOLD</b>		14. NAME OF HUSBAND OR WIFE <b>AUGUSTA RETZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>			17. INFORMANT Address <b>AUGUSTA RETZ (WIDOW) SEE # 2</b>		
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) <b>CEREBRAL VASCULAR ACCIDENT</b>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>					
DUE TO (c) <b>422.1</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>BRONCHOPNEUMONIA</b>				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 checked="" type="checkbox"/> NO <input 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. <b>VA</b> attended the deceased from <b>8/7/61</b> to <b>8/18/61</b> and last saw him alive on <b>8/18/61</b> Death occurred at <b>9:50 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Type or print) <b>ANDREW W. MC ROBERTS</b>			22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		22c. DATE SIGNED <b>8/19/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>August 22, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S. S. PETER &amp; PAUL CEMETERY, St. Louis, Mo.</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>WITT BROS. L. &amp; U. CO. 6409 Gravois Ave. (16)</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 21 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith. M. D.</b>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF  
 MEDICAL CERTIFICATION  
 DOCUMENT  
 INSTEAD 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 Herbert J. Lan Jr  
Licensed Embalmer No. 4800  
P. O. Address Kirkwood, 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.