

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

8352 -61-034341
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED SEP 18 1961

DATE AMENDED

INSTEAD OF

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 <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>6 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DePaul Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>5321 Conde Ave.</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>GEISZ</u> Last			4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1961</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/1874</u>
9. AGE (last birthday) <u>86 years</u>		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) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
13a. FATHER'S NAME <u>Joseph Walter</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Emmendorf</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
17. INFORMANT Address <u>Clarice Bull - 5321 Conde Ave.</u>		14. NAME OF HUSBAND OR WIFE <u>George Geisz Sr.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
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>Myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Arteriosclerotic coronary thrombosis</u>			<u>10 days</u>
DUE TO (c) <u>Arteriosclerotic heart disease</u>			<u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute cholecystitis</u>			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 <u>August 30, 1961</u> to <u>September 6, 1961</u> and last saw her <u>alive</u> on <u>September 6, 1961</u> Death occurred at <u>540 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John T. Lawton, M.A.</u>		22b. ADDRESS <u>634 N. Grand Blvd.</u>	
22c. DATE SIGNED <u>Sept. 7, 1961</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Sept. 9, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>BUCHHEIZ MORTUARY-5967 W. Florissant Ave</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 8 1961</u>	
26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>			

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 Roepk. C. Linders

Licensed Embalmer No. 4575

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.