

DEPARTMENT OF PUBLIC HEALTH AND WELFARE  
 MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

9959-61-039307  
 STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9959-61-039307**

**FILED NOV 8 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4535 ALASKA</b>		d. STREET ADDRESS (If outside, give location) <b>4535 ALASKA</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>TINES</b> Last			4. DATE OF DEATH Month <b>OCT.</b> Day <b>26</b> Year <b>1961</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>OCT. 1 1893</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CABINET MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ROUMANIA</b>	12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>
13a. FATHER'S NAME <b>ANTON TINES</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA ROSENACKER</b>		14. NAME OF HUSBAND OR WIFE <b>GIZELLA TINES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			17. INFORMANT Address <b>ANTON TINES 4711 COLLINS CT.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 WEEKS</b>
DUE TO (b) <b>GENERAL ARTERIO SCLEROSIS</b>		
DUE TO (c) <b>331X</b>		
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 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 <b>5:30A</b> Month, Day, Year <b>8-25-61</b>		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 <b>8-25-61</b> to <b>10-26-61</b> and last saw <sup>him</sup> him alive on <b>10-25-61</b> Death occurred at <b>530A</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <b>O &amp; Jones</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>3616 S. BROADWAY; ST. LOUIS</b>		22c. DATE SIGNED <b>10-27-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>OCT. 28, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>	
23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS CO, MO</b>		24. FUNERAL DIRECTOR <b>Thomas Hites 2906 Gravin</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 27 1961</b>	
26. REGISTRAR'S SIGNATURE <b>Neal Smith, M.D.</b>					

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Edward Poirnee

Licensed Embalmer No. 3 f 0 3

P. O. Address 2906 Glen

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.