

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042471

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11131 STATE FILE NUMBER

AMENDED

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>2 yrs. 11</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp.</u>		Inside Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2812 Magnolia</u> Reside on Farm: Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Mamie Middle Last Hana 4. DATE OF DEATH Month 11 Day 29 Year 61

5. SEX Female 6. COLOR OR RACE White 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH MARCH 17, 1906 9. AGE (last birthday) 75 IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 10b. KIND OF BUSINESS OR INDUSTRY HOME 11. BIRTHPLACE (City and state or country) Austria 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Frank 13b. MOTHER'S MAIDEN NAME Rose 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. NONE 17. INFORMANT ANNA ECKRICH 3736 COMPTON Address

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 thrombosis  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 332x  
DUE TO (c)

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.  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 Month, Day, Year s.m. p.m.

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 12-29-58 to 11-29-61 and last saw her/him alive on 11-29-61  
Death occurred at 6:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Deedee or title) 22b. ADDRESS 5800 Arsenal St. 22c. DATE SIGNED 11/29/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE DEC. 1 1961 23c. NAME OF CEMETERY OR CREMATORY PETER + PAUL 23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.

24. FUNERAL DIRECTOR THOMAS KUTIS 2906 GRAVOIS ADDRESS 25. DATE RECD. BY LOCAL REG. NOV 30 1961 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

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 James C. Hill

Licensed Embalmer No. 4347  
P. O. Address 2906 St. ...

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.