SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

-61-042688

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10841

FILED NOV 28 1961

AMENDED

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 HOSPITAL OR INSTITUTION (If NOT in hospital, give location): MARIAN HOSPITAL — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY

c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 3004 a LOUISIANA AVE — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JOSEPH Middle V Last MARTINEK

4. DATE OF DEATH: Month NOV Day 20 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: DEC. 23 1876

9. AGE (last birthday): 84 — 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): MAINTENANCE MAN AT DE PAUL HOSPITAL

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): MISSOURI

12. CITIZEN OF WHAT COUNTRY: U-S-A

13a. FATHER'S NAME: FRANK MARTINEK

13b. MOTHER'S MAIDEN NAME: MARY KALLASH

14. NAME OF HUSBAND OR WIFE: CECILIA MARTINEK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

17. INFORMANT: CECILIA MARTINEK — Address: 3004 a LOUISIANA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ruptured abdominal aneurism(Aortic) — INTERVAL BETWEEN ONSET AND DEATH: 6 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Sclerosis of vessel

DUE TO (c): 451X

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 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 11/14/61, to 11/20/61 and last saw ~~her~~ him alive on 11/17/61

Death occurred at Marian Hospital 1:30A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Chas F Henke MD

22b. ADDRESS: 3109 S.Grand Blvd.

22c. DATE SIGNED: 11/20/61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: NOV. 22 1961

23c. NAME OF CEMETERY OR CREMATORY: ST. PETER + PAUL CEM.

23d. LOCATION (City, town, or county): ST. LOUIS (State): MO.

24. FUNERAL DIRECTOR: Thomas Kutis — ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: NOV 21 1961

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 Eleanor Pavine

Licensed Embalmer No. 3403

P. O. Address 7906 Grava

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.