

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

12029

-61-046535  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District 1003 Registrar's No. \_\_\_\_\_

AMENDED

FILED JAN 5 1962

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>		Length of stay in 1b <u>1 year</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1508 Orchid Avenue</u>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		d. STREET ADDRESS (If outside, give location) <u>1508 Orchid Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>Kubatzky</u> Last <u>Kubatzky</u>			4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1961</u>			
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-1869</u>	9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chairman of Board (retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Winco Ventilator Co</u>	11. BIRTHPLACE (City and state or country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>--- Kubatzky</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Lorena Kubatzky</u>
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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.	17. INFORMANT <u>Mr. Woodrow Kubatzky, 533 Bittner St</u> Address
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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>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>334x</u>		

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"/> N: <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 <u>St. Louis</u>	COUNTY <u>St. Louis</u>	STATE
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21. I attended the deceased from <u>Jan 19 59</u> to <u>12/21/61</u> and last saw <del>him</del> <u>her</u> alive on <u>12/20/61</u> Death occurred at <u>4:45 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>7205 W. Flouissant</u>	22c. DATE SIGNED <u>12/22/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec. 23, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
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24. FUNERAL DIRECTOR <u>Math Hermann &amp; Son, Inc.</u> ADDRESS <u>2161 E. Fair Ave</u> <u>St. Louis, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 23 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

IF AMENDED OR CORRECTED, THIS SHOULD BE INDICATED IN THE MARGINS

IF NEW NO. IS ENTERED, THIS SHOULD BE INDICATED IN THE MARGINS

**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 \_\_\_\_\_

*Walter G Burnley*

Licensed Embalmer No. 4202

P. O. Address St Louis

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.