SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-046815

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12327

FILED JAN 11 1962

1. PLACE OF DEATH
a. COUNTY

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

b. CITY OR TOWN ST. LOUIS | Length of stay in 1b

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

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. ANTHONY HOSPITAL | Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 1820 a ANN AVE | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: DOROTHY Middle: T Last: SAFFA

4. DATE OF DEATH Month: DEC. Day: 29 Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: JAN 7 1924

9. AGE (last birthday): 37

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): STENOGRAPHER

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: ROBERT MONTGOMERY

13b. MOTHER'S MAIDEN NAME: VIRGINIA BARNES

14. NAME OF HUSBAND OR WIFE: MICHAEL D. SAFFA

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

17. INFORMANT: MICHAEL D. SAFFA Address: 1820 a ANN AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute congestive failure	3 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Acute tracheal bronchitis	2 days
DUE TO (c)	Acute bronchialitis	???

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 500X

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 March 3, 1961 to December 29, 1961 and last saw her/him alive on Dec. 29, 1961

Death occurred at 6 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M.D.

22b. ADDRESS 4145 a S. Grand Blvd.

22c. DATE SIGNED 12.30.61

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

23b. DATE: JAN 2 1962

23c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEM.

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

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: JAN 2 1962

26. REGISTRAR'S SIGNATURE: Paul Smith, M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4861

P. O. Address _____

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.