MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

ARTMENT OF PUBLIC HEALTH AND WELFARE

61-047855

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3747

FILED JAN 19 1962

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED 3 91

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Koch, Missouri
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 44 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Robt. Koch Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2329 South Third — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Steve — Middle — Last Duich
4. DATE OF DEATH: Month Dec. Day 27, Year 1961
5. SEX: male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐ Unk
8. DATE OF BIRTH: 10-30-78
9. AGE (last birthday): 83 yrs. — 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): nil
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Yugoslavia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Frank Duich
13b. MOTHER'S MAIDEN NAME: Kate ?
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Koch Hosp. record, Koch, Mo. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
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 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 11-13-61, to 12-27-61 and last saw her/him alive on 12-27-61
Death occurred at 10:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Axel R. Gronau M.D.
22b. ADDRESS: Robt. Koch Hosp. Koch, Mo.
22c. DATE SIGNED: 12-27-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 12/29/61
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county): St. Louis (State): Mo.

24. FUNERAL DIRECTOR: Collins Kelly — ADDRESS: 7267 Natural Bridge
25. DATE RECD. BY LOCAL REG.: 12-29-61
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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. Not Embalmed

Student_____ Signed James A Lommen

Signature of Student Embalmer

Licensed Embalmer No. 4142

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.