

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004874  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 129

AMENDED

FILED JAN 19 1962

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>St. Louis</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ellisville</b>		Length of stay in lb <b>2 mos.</b>		a. STATE <b>Wisconsin</b> COUNTY <b>Sheboygan</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Sunset Sanitarium</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Sheboygan</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				d. STREET ADDRESS (If outside, give location) <b>1954 N. 6th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Month Day Year	
First <b>GEORGE</b>		Middle <b>ABBOTT</b>		Last <b>GLICK</b>		<b>Jan 10, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-1888</b>	9. AGE (last birthday) <b>73</b>	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) <b>Ret. Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Reiss Coal Co.</b>		11. BIRTHPLACE (City and state or country) <b>Marshalltown, Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Albert Glick</b>			13b. MOTHER'S MAIDEN NAME <b>Helen Abbott</b>			14. NAME OF HUSBAND OR WIFE <b>Maude Glick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>[Redacted]</b>		17. INFORMANT <b>Kirkwood 22</b> Address <b>Missouri</b> <b>Nancy Sarff-317 N. Woodlawn</b>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cardiovascular renal syndrome</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <b>Emphysema - myocardial infarction</b>							<b>year</b>
DUE TO (c) <b>Benign Prostate - Surgery 11-61</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>terminal brain state</b>						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	
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
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		COUNTY	STATE
21. I attended the deceased from <u>11-1-61</u> to <u>1-9-62</u> and last saw her alive on <u>1-9-62</u> Death occurred at <u>12 noon</u> <u>1-10-62</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Robert Bruno MD</b> (Degree or title)				22b. ADDRESS <b>109 N. Taylor Kirkwood</b>		22c. DATE SIGNED <b>1-11-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-11-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wildwood Cem.</b>		23d. LOCATION (City, town, or county) <b>Sheboygan, Wisc.</b> (State)		
24. FUNERAL DIRECTOR <b>Pfizinger Mort-Kirkwood 22, Mo.</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>1-11-62</b>		26. REGISTRAR'S SIGNATURE <b>John B. Murphy MD</b>		

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

**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 *Benjamin H. Johnson*

Licensed Embalmer No. 4366

P. O. Address St Louis, Mo.

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.