

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017304

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4348**

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 10 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY		c. CITY OR TOWN <b>ST. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LUTHERAN HOSP.</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3428 MINNESOTA</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAGDALENA</b> Middle <b>STITZEL</b> Last						4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>1962</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-23-1904</b>		9. AGE (last birthday) <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>MAX Mueller</b>				13b. MOTHER'S MAIDEN NAME <b>BARBARA Hommel</b>				14. NAME OF HUSBAND OR WIFE <b>Nickolas STITZEL</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>None</b>		17. INFORMANT Address <b>Nickolas STITZEL 3428 MINNESOTA</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis Stage advanced</b> DUE TO (b) <b>Carcinoma left Breast</b> DUE TO (c) <b>170x</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 yrs.</b>	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>3/8/58</b> to <b>4/25/62</b> and last saw her alive on <b>4/25/62</b> Death occurred at <b>12:50 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <b>Robert H. Carson M.D.</b> (Deceased or title)						22b. ADDRESS <b>4401 Hampton Ave</b>			22c. DATE SIGNED <b>4/26/62</b> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>APRIL 28, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION Cem.</b>		23d. LOCATION (City, town, or county) <b>ST. Louis 90 Mo</b>					
24. FUNERAL DIRECTOR <b>Thomas Kutis 2906 Grand</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>APR 27 1962</b>		26. REGISTRAR'S SIGNATURE <b>Robert Smith, M.D.</b>					

USE BLACK INK OR TYPEWRITER RIBBON

Mr. S. Carr  
4401 Hampton

HL 1-9510 2-3 Thurs.

**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 Bourice

Licensed Embalmer No. 3403

P. O. Address 2906 glenn

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.