

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036173
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9143**

FILED OCT 3 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 1 week | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois COUNTY St. Clair | | c. CITY OR TOWN Fairmont City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hosp. | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3621 Maple Ave. | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GENARO (none) GARCIA | | | | | | 4. DATE OF DEATH Month Day Year Sept. 20, 1962 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 8-15-91 71 | | 9. AGE (last birthday) 71 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Smelter Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Zinc Foundry | | 11. BIRTHPLACE (City and state or country) Asturias, Spain | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13a. FATHER'S NAME Manuel Garcia | | | | 13b. MOTHER'S MAIDEN NAME Rose Gutierrez | | | | 14. NAME OF HUSBAND OR WIFE Caroline Garcia | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Caroline Garcia Address 3621 Maple Ave. E. St. Louis, Ill. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute circulatory failure | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) acute cholecystitis (possible empyema), edema of the pancreas, diabetes mellitus, arteriosclerotic DUE TO (c) heart disease with auricular fibrillation. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 585x | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <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 a.m. p.m. | | Month, Day, Year. | | | | | | | | | |
| 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 Sept. 14, 1962 to Sept. 20, 1962 and last saw her/him alive on Sept. 20, 1962 Death occurred at 9:05 PM m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Dr. Hermann Moses M.D. | | | | | | 22b. ADDRESS 508 N. Grand Ave. | | | 22c. DATE SIGNED 9/21/62 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 9-24-62 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | | | | |
| 24. FUNERAL DIRECTOR John J. Kassly, E. St. Louis, Ill. | | | | | | 25. DATE RECD. BY LOCAL REG. SEP 21 1962 | | 26. REGISTRAR'S SIGNATURE Lois Smith, M.D. | | | |

USE BLACK INK OR TYPEWRITER RIBBON

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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 John Kossly III

Licensed Embalmer No. 5039

P. O. Address E. St Louis, Ill.

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.