

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044280

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary, Registration District No. 1003 Registrar's No. 11064

STATE FILE NUMBER

**FILED DEC 14 1962**

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in lb		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>5412 Partridge</u>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle Last <u>Grbcich</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/1895/67</u>
9. AGE (last birthday) <u>67</u>		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) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ry. Ex. Bldg.</u>	11. BIRTHPLACE (City and state or country) <u>Yugoslavia</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13. FATHER'S NAME <u>Thomas Perhat</u>	
14. NAME OF HUSBAND OR WIFE <u>Mate Grbcich Decd.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Walter Grbcich 5920 Lucille</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Fracture of pelvis.</u> DUE TO (c) <u>904.0-21</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Conditions, if any, which give rise to above cause (a), stating the underlying cause last.</u>			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell at home.</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>11-3-'62</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		
20f. CITY, TOWN, OR LOCATION <u>St. Louis, Missouri</u>		20g. COUNTY STATE	
21. I attended the deceased from <u>11-6-'62</u> to <u>11-15-'62</u> and last saw her/him alive on <u>11-15-'62</u> Death occurred at <u>9:55a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Walter F Shaul M.D.</u>		22b. ADDRESS <u>Northland Medical Bldg. St. Louis 36, Mo.</u>	
22c. DATE SIGNED <u>12-4-'62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>11/19/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
24. FUNERAL DIRECTOR <u>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD.</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 18 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

**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 *JM Rister*

Licensed Embalmer No. 3980

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.