

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-048419

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12519**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963

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

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
		<b>ST. LOUIS</b>				<b>MO</b>				<b>ST. LOUIS</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS								Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
												<b>3961 BATES</b>			
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			
			<b>KITTY</b>			<b>AMSLER</b>			<b>HOELZLE</b>			Month Day Year <b>12 26 1962</b>			
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
<b>FEMALE</b>		<b>WHITE</b>				<b>FEB 13 1888</b>		<b>74</b>		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY			
<b>SECY. TREAS. WAITRESSES UNION #249</b>								<b>MO.</b>				<b>U. S. A.</b>			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
<b>EDWARD O'ROURKE</b>				<b>MARY O'BRIEN</b>				<b>FRANK HOELZLE</b>							
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.				17. INFORMANT				Address			
<b>NO</b>								<b>FRANK HOELZLE 3961 BATES</b>							
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)															
<b>Acute myocardial infarction</b>															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.															
DUE TO (b)															
DUE TO (c)												<b>420.1</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 checked="" type="checkbox"/> NO <input 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.		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>Dec 17</b> to <b>Dec 26</b> and last saw her/him alive on <b>Dec 26-62</b> Death occurred <b>St. Mary's Hospital</b> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED						
<b>Edwin M. Smith M.D.</b>						<b>16 Hampton Valley Plaza</b>			<b>12-29-62</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)				
<b>REMOVAL</b>			<b>12/31/62</b>		<b>SUNSET BURIAL PARK</b>			<b>ST. LOUIS CO. MO.</b>							
24. FUNERAL DIRECTOR				ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
<b>Thomas Kuttia</b>				<b>2906 Gravois</b>				<b>12-28-1962</b>		<b>Earl Smith, M.D.</b>					

**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 Carol Thompson Jr.

Licensed Embalmer No. 4861

P. O. Address St Louis 19, 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.