

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003689

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1063**

**FILED FEB 8 1963**

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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

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS</b>  |   | a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>DEACONESS HOSPITAL</b>   |   | c. CITY OR TOWN <b>BRIDGETON</b>  |   |
| d. STREET ADDRESS <b>12796 GIST ROAD</b>   |   | d. STREET ADDRESS (If outside, give location)   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LOYD</b> Middle <b>MARIE</b> Last <b>KALLIAL</b>   |   | 4. DATE OF DEATH<br>Month <b>JAN</b> Day <b>30</b> Year <b>1963</b>   |   |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>                     | 8. DATE OF BIRTH <b>APR 3 1912</b>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SECRETARY + TREAS. OF LASALLE FUR CO</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>ILLINOIS</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>U-S-A</b> |
| 13a. FATHER'S NAME<br><b>HARRY MAITLAND</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>SHAKIER KALLIAL</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)<br><b>NO</b>  |   | 17. INFORMANT<br><b>SHAKIER KALLIAL 12796 GIST ROAD</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>   |   |
| DUE TO (b) <b>Arteriosclerotic Vascular Dis.</b>   |   |   |   |
| DUE TO (c) <b>Sepsisemia</b>   |   | <b>331X B</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Chronic Renal Disease</b>  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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<br>COUNTY _____ STATE _____  |   |
| 21. I attended the deceased from <b>Jan 27 1963</b> to <b>Jan 30 1963</b> and last saw her/him alive on <b>Jan 30 1963</b><br>Death occurred at <b>7:15 P</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Shaker Kallial MD</b>   |   | 22b. ADDRESS<br><b>6500 Chippewa Shaws</b>  |   |
|  |   | 22c. DATE SIGNED<br><b>1/31/63</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>  |   | 23b. DATE<br><b>FEB 2 1963</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>RESURRECTION CEM.</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>ST. LOUIS CO. MO.</b>   |   |
| 24. GENERAL DIRECTOR<br><b>Thomas Kutia 2906 Gravois</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 31 1963</b>  |   |
|  |   | 26. REGISTRAR'S SIGNATURE<br><b>Roald Smith, M.D.</b>   |   |

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 *Robert H. [Signature]*  
Licensed Embalmer No. 4867

P. O. Address *H. [Signature] 19 [Signature]*

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.

*Dr. Phillip [Signature]*  
*6500 [Signature]*  
*5X 2-8383*  
*to 5*