

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26643

STATE FILE NUMBER

FILED JUL 26 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **6694**

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. General: Operation for Ventral Hernia

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospt. Length of stay in 1b 40 Years | | STREET ADDRESS 2513 Mullamphy Street (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First VERLIE Middle TOLIAS Last TOLIAS | | | 4. DATE OF DEATH Month July Day 16 Year 1957 |
| 5. SEX Female | 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 Nov. 13 1903 |
| 9. AGE (In years last birthday) 53 | | IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53 | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Solderer | | 10b. KIND OF BUSINESS OR INDUSTRY S. G. Adams Co. | 11. BIRTHPLACE (City and state or country) Calhoun County, Illinois |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Walter Kress | |
| 14. MOTHER'S MAIDEN NAME Abbie Bell | | 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. 496-18-1274 | | 17. INFORMANT Address Speros Tolias 2513 Mullamphy St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Post-op Intestinal Obstruction DUE TO (c) Obesity 561.3 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH 16 Hrs. |
| 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 Month, Day, Year 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 7-8-57 to 7-16-57 and last saw her live on 7-16-57 Death occurred at 1:15 p. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Aug. W. Geise (Degree or title) M.D. M.D. | | 22b. ADDRESS 5535 Delmar | |
| 22c. DATE SIGNED 7-16-57 | | 22d. ADDRESS 5535 Delmar | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE July 19 1957 | |
| 23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, -County, -Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS Beiderwieden F. H. Inc. 1936 St. Louis Ave. | | 25. DATE RECD. BY LOCAL REG. JUL 18 '57 | |
| 26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | | |

(Licensed Embalmer's Statement on Reverse Side)

2701

81E

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 Delit J. Krupar
Licensed Embalmer No. 34

P. O. Address St. Louis

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.