

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011606
STATE FILE NUMBER 2429

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. _____

300
-57

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) ST LOUIS,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST LOUIS, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 07 CHRISTIAN HOSPITAL		Length of stay in lb 2 WEEKS	d. STREET ADDRESS (If outside, give location) 3518 DODIER AVE 1090
3. NAME OF DECEASED (Type or print) First MIDDLE Last FRED J. FLAIZ SR.			4. DATE OF DEATH Month Day Year FEB, 26. 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 7, 1885
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) QUINCY ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME FRANK FLAIZ	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE	
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. 493-07-7201	17. INFORMANT FRED J. FLAIZ 1481 WEST LINCOLN BIRMINGHAM MICHIGAN
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Insufficiency DUE TO (c) 420-1F PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) aggravated by fall suffered			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.) at 3502 North Grand Ave.; on	
20c. TIME OF INJURY Hour a.m. p.m. 2 3 58 February 3 1958		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 10	
20e. CITY, TOWN, OR LOCATION ST LOUIS		20f. COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 8:25 pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree of title) J. Carl Smith, M.D.		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 2/28/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/1/58	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI
24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE AVE		25. DATE RECD. BY LOCAL REG. FEB 28 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. 2. 8. 12

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Carroll

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 M W B. Meter

Licensed Embalmer No. 4865

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.