

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003592
STATE FILE NUMBER
2 1050

FILED FEB 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. Lukes. Hosp</u>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>3109 3834 9 Labadie</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jacob Vitt</u>				4. DATE OF DEATH Month Day Year <u>JAN 28, 1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-7-1878</u>		9. AGE (In years at birthday) <u>80</u> 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) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>492-05-8182</u>		11. BIRTHPLACE (City and state or country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Paul Vitt</u>			13b. MOTHER'S MAIDEN NAME <u>Not Known</u>			14. NAME OF HUSBAND OR WIFE <u>—</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 Address <u>Hilda Vitt 4756 Bonita</u>				
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.		DUE TO (b) <u>Cerebrovascular accident, probable</u>		DUE TO (c) <u>Generalized arteriosclerosis</u>		Interval <u>11 days</u>		Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Not related to the terminal disease condition given in PART I (a)) <u>Tumor or cyst of left kidney, (which may have caused cerebral metastases)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>331X</u>						
20c. TIME OF INJURY Hour a.m. p.m. 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 COUNTY STATE		
21. I attended the deceased from <u>Aug 20, 1956</u> to <u>Jan 28, 1959</u> and last saw him alive on <u>January 27, 1959</u> Death occurred at <u>8:11 p</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Donald H. Smith, M.D.</u>				22b. ADDRESS <u>4110 West Florissant Ave.</u>			22c. DATE SIGNED <u>Jan 29, 1959</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-31-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>		23d. LOCATION (City, town, or county) (State) <u>ST. Louis Co Mo</u>			
24. FUNERAL DIRECTOR <u>A. Kou</u>			ADDRESS <u>2707 91 Grand</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 29 '59</u>		26. REGISTRAR'S SIGNATURE <u>Donald Smith, M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

mjb

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 *Harvey Kable*

Licensed Embalmer No. *4596*

P. O. Address *Floissant, N*

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.