

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007473

STATE FILE NUMBER

21808

FILED MAR 10 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57
10
74

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
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>De Paul Hosp.</u>		Length of stay in lb <u>34 YRS.</u>	d. STREET ADDRESS (If outside, give location) <u>4603 Westminister</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Neal</u> Middle <u>Woodford</u> Last <u>MOTTIS</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV-1-1884</u>
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during present working life, or if retired) <u>Field Insp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Water Dept.</u>	11. BIRTHPLACE (City and state or country) <u>Medicine Lodge - KANSAS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MARRIED NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>EMMA MOTTIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>493-10-1375</u>	17. INFORMANT <u>Emma Morris</u> Address <u>St. Louis Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>an</u> DUE TO (c) <u>157X</u> 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 <u>unknown</u>
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 _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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>2/12/59</u> to <u>2/19/59</u> and last saw him alive on <u>2/19/59</u> Death occurred at <u>3:15 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert Potashnick M.D.</u>		22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>2/20/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2/20/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>College Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Lebanon Illinois</u>
24. FUNERAL DIRECTOR <u>Meyer</u>	ADDRESS <u>Lebanon, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 20 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Frank Trovoff*

Licensed Embalmer No. *4356*

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.