

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010661

STATE FILE NUMBER

Registration No. 2255

MAR 17 1959

Registration District No. Primary Registration District No.

Registration No. 2255

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Adams	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Quincy	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 1100 No. 10th, St.	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS F. ALTHOFF			4. DATE OF DEATH Month Day Year MARCH 3, 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1941
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	10c. AGE (In years last birthday) 17
11. BIRTHPLACE (City and state or country) Quincy, Illinois.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Fritz C. Althoff		13b. MOTHER'S MAIDEN NAME Dorothy Tenk	14. NAME OF HUSBAND OR WIFE Nil.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. None	17. INFORMANT Fritz C. Althoff, 1100 N. 10th Quincy, Ill.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ABSCESS, LEFT TEMPORAL LOBE, ETIOLOGY UNDETERMINED			INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 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 MARCH 1, 1959 to MARCH 3, 1959 and last saw her/him alive on MARCH 3, 1959 Death occurred at 12:01 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. P. Verullia, M. D.</i>		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/3/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-6-59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) Quincy, Illinois.		(State)	
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. MAR 4 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M. D.</i>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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1-57
C
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Health,
Welfare
Public
Service

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21.15

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 Elton H. Remelius

Licensed Embalmer No. 4285

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.