

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011337

STATE FILE NUMBER

FILED MAR 17

Registration District No.

Primary Registration District No.

Registration No.

2-2038

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
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 <b>ALEXIAN BROS. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>3343 WISCONSIN</b>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>VASIL W ROTTAR</b>			4. DATE OF DEATH Month Day Year <b>FEB 24 1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 18 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>HUNGARY</b>
12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>		13a. FATHER'S NAME <b>UNKNOWN</b>	
13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>MARGARET ROTTAR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MARGARET ROTTAR</b>		Address <b>3343 WISCONSIN</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis with infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>420.1</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Virus pneumonia; femoral venous thrombosis - left</b>			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.)	
20c. TIME OF INJURY Hour a.m. 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 <b>15 Feb. 1959</b> to <b>24 Feb. 59</b> and last saw him alive on <b>24 Feb. 1959</b> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert S. Nyc, M.D.</b> (Degree or title)		22b. ADDRESS <b>3201 Arsenal St. St. Louis Mo</b>	
22c. DATE SIGNED <b>25 Feb. 1959</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL FEB 27 1959</b>		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY <b>ST MATTHEW CEM</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>	
24. FUNERAL DIRECTOR <b>Thomas Kute 2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 26 '59</b>	
ADDRESS		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

12-3-2011 0111

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 *James O Hill* ..... Licensed Embalmer No. .... P. O. Address. ....

Licensed Embalmer No. *4347* ..... P. O. Address. *2906 Duane* .....

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.