

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023468

STATE FILE NUMBER

Registration No. **5437**

FILED JUN 18 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registration No. **5437**

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v. 1-57  
38  
41  
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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

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 <b>St. Louis Mo.</b> TOWN		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Bros.</b>		d. STREET ADDRESS (If outside, give location) <b>3449 California</b>	
3. NAME OF DECEASED (Type or print) <b>Otto A. Tockstein</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>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>Nov 26 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hamilton Shoe</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>
13a. FATHER'S NAME <b>Ladislav Tockstein</b>		13b. MOTHER'S MAIDEN NAME <b>Elizsabeth Fialha</b>	14. NAME OF HUSBAND OR WIFE <b>Ruth Tockstein</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>494057351</b>	17. INFORMANT Address <b>Ruth Tockstein 3449 California</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>Bronchogenic Carcinoma of right lung</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>162.1</b>
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 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 _____ .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 <b>March 1959</b> to <b>June 1959</b> and last saw her alive on <b>6-5-59</b> Death occurred at <b>6:30 Pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John J. Orsler, M.D.</b> (Degree or title)		22b. ADDRESS <b>5203 Chipping</b>	22c. DATE SIGNED <b>6-6-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-8-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Moydell Funeral Home 1926 Allen</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 8 59</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b> <i>mdb</i>

(Licensed Embalmer's Statement on Reverse Side)

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 *Shelley R. Jaeller Jr* .....

Licensed Embalmer No. *4950* .....

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.