

FILED VS. JUL 30 1959

2 6747

STATE FILE NUMBER

DED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		d. STREET ADDRESS (If outside, give location) <b>1027 S. Boyle</b>	

3. NAME OF DECEASED (Type or print) <b>SAMUEL POLITE</b>			4. DATE OF DEATH <b>July 17, 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>3/20/92</b>	9. AGE (last birthday) <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Potosi Mo.</b>	
12. - CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Gus Politte</b>		
14. NAME OF HUSBAND OR WIFE <b>Minnie E. Politte</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes #1</b>		
16. SOCIAL SECURITY NO. <b>Nnk</b>		17. INFORMANT <b>Minnie E. Politte St. Louis Mo.</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) **Cerebral Vascular Accident**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Generalized Arteriosclerosis**

DUE TO (c) **331x**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Abscess of left inguinal region**

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO

20a. ACCIDENT  SUICIDE  HOMICIDE

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 \_\_\_\_\_

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

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 **7/13/59** to **7/17/59** and last saw her alive on **7/17/59**

Death occurred at **9:26 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Tom R. Burcham MD**

22b. ADDRESS **1515 LAFAYETTE AVE**

22c. DATE SIGNED **7/17/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

23b. DATE **7/20/59**

23c. NAME OF CEMETERY OR CREMATORY **National Cem.**

23d. LOCATION (City, town, or county) (State) **St. Louis Mo.**

24. FUNERAL DIRECTOR ADDRESS **Rowland-Aker Mortuary St. Louis Mo.**

25. DATE RECD. BY LOCAL REG. **JUL 20 1959**

26. REGISTRAR'S SIGNATURE **Earl Smith, M.D.**

*mjb*

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey Fahle

Licensed Embalmer No. 4596

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.