

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-008145**

**FILED VS FEB 25 1960**

**2 1868**

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4965 Wise Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>STEPHEN</b> Middle <b>L. (ETIENNE)</b> Last <b>DROZ</b>						4. DATE OF DEATH Month <b>Feb.</b> Day <b>15</b> Year <b>1960</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>10-9-1902</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental Technician-Frein Dental Lab. Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis, Mo.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Louis Droz</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Gaboid</b>			14. NAME OF HUSBAND OR WIFE <b>Mary Droz</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>496-22-3440</b>		17. INFORMANT <b>Mary Droz</b> Address <b>4965 Wise Ave.</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>Uremia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic Glomerular nephritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs(?)</b>	
DUE TO (c) <b>592x</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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. _____ p.m. Month, Day, Year _____		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>1-14-60</b> to <b>2-15-60</b> and last saw him alive on <b>2-14-60</b> Death occurred at <b>3:50 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>William A. Turner M.D.</b>				22b. ADDRESS <b>4401 Hampton</b>		22c. DATE SIGNED <b>2-6-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 18, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		
24. FUNERAL DIRECTOR <b>Kriegshauser</b> ADDRESS <b>4228 S. Kingshighway</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 17 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>		

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

*William S. White*

Licensed Embalmer No. *4291*

P. O. Address *1228 ...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.