

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020900

FILED VS JUN 9 1960 318

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5593

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>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>4 days</b>		c. CITY OR TOWN <b>St. Louis</b>		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>De Paul Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4029 Ashland Avenue</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Marie (Mary)</b> Middle <b>Fabian</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-6-1876</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		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>Joseph Somagyi</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>			14. NAME OF HUSBAND OR WIFE <b>deceased</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.		17. INFORMANT Address <b>Miss Irene Fabian, 4029 Ashland Avenue</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>Myocardial infarction</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Atherosclerotic coronary thrombosis</b> DUE TO (c) <b>4201</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>May 26, 1960</b> to <b>May 29, 1960</b> and last saw <sup>her</sup> <b>XXX</b> alive on <b>May 29, 1960</b> Death occurred at <b>1:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>John T. Lawton, M.D.</b>				22b. ADDRESS <b>634 N. Grand Blvd.</b>		22c. DATE SIGNED <b>May 31, 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 1, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 31 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

*Walter W. Hays*

Licensed Embalmer No. *3737*

P. O. Address *St. Louis*

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.