

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028987

FILED VS AUG 8 1960

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2247

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST. LOUIS</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Length of stay in 1b <u>1HR.</u>		c. CITY OR TOWN <u>FENTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH'S</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>HAWKINS ROAD</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES JOSEPH MRAZ</u>				4. DATE OF DEATH Month Day Year <u>7 24 60</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/2/1958</u>		9. AGE (last birthday) <u>71</u>		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) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>FENTON</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>JOSEPH MRAZ</u>				13b. MOTHER'S MAIDEN NAME <u>unk</u>				14. NAME OF HUSBAND OR WIFE <u>VIRGINIA McCORD</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>				16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>RICHARD C. MRAZ</u> Address <u>Box 156A RR#2 MRAZ MEADOWS</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Carcinoma of prostate suspected</u>										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 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 <u>1958</u> to <u>7-24-60</u> and last saw him alive on <u>7-24-60</u> Death occurred at <u>12:40 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Deleged or title) <u>Charles Miller MD</u>						22b. ADDRESS <u>206 N. Clay, Kirkwood</u>				22c. DATE SIGNED <u>7-26-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7-29-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHURC ST. PAULS CATHOLIC</u>				23d. LOCATION (City, town, or county) <u>FENTON ST. LOUIS Mo</u>					
24. FUNERAL DIRECTOR <u>LEO H. FIESER SR</u>					ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7-27-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>				

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Daniel J. Mahan

Licensed Embalmer No. 4326

P. O. Address Albany, TN

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.