

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040619

FILED VS NOV 2 1960

INDEXED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2974 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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		c. CITY OR TOWN <u>ST. LOUIS</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>MILLER NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>4150 Miami</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY BARTONETZ-(BARTONEZ)</u>			4. DATE OF DEATH Month Day Year <u>OCT. 10 1960</u>		
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5. SEX <u>FEMALE</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>JUNE 27 1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>BOHEMIA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>FRANK HABA</u>	13b. MOTHER'S MAIDEN NAME <u>unk</u>	14. NAME OF HUSBAND OR WIFE <u>WILLIAM BARTONETZ</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>EMILY DE WALLE 4150 Miami</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Cardiac insufficiency</u> <u>1 Mo.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Acute Interstitial Nephritis</u> <u>1 wk.</u>	
	<u>Chronic Arteriosclerosis</u> <u>1 yr.</u>	

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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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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
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21. I attended the deceased from <u>June 14th 1960</u> to <u>Oct. 10, 1960</u> and last saw her/him alive on <u>Oct. 9th, 1960</u>
Death occurred at <u>5</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. H. Walters M.D.</u>	22b. ADDRESS <u>3608 S. Grand Blvd.,</u>	22c. DATE SIGNED <u>10/10/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 13 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST. MARCUS</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. Mo.</u>
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24. FUNERAL DIRECTOR <u>Thomas Kutas 2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>10-11-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

Quantity - 1000

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 *Henry Province*

Licensed Embalmer No. *3403*

P. O. Address *7906 9th*

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.