MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4642 STATE FILE NUMBER 61-019278

FILED MAY 19 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4532 Tower Grove Place
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JENNIE Middle E. Last MITSCHRICH
4. DATE OF DEATH: Month MAY Day 14 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 7-5-1888
9. AGE (last birthday): 72
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): Housework
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (City and state or country): Trenton, Illinois
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Fred Menzi
13b. MOTHER'S MAIDEN NAME: Margaret Kuhn
14. NAME OF HUSBAND OR WIFE: Melville F.Mitschrich
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Melville F.Mitschrich Address: 4532 Tower Gr.Pl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 6 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE — FEW YEARS
DUE TO (c): 420.0
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PEREORMED? 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 a.m. p.m. 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 4/28/61, to 5/14/61 and last saw her/him alive on 5/14/61
Death occurred at 11:00 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE C. Vermillion, M.D. (Degree or title) M. D.
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 5/15/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 5-17-1961
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): St.Louis Co.,Mo.
24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S.Kingshighway Blvd.
25. DATE RECD. BY LOCAL REG.: MAY 16 1961
26. REGISTRAR'S SIGNATURE: Noel Smith, M.D.

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 R. W. Stoveand

Licensed Embalmer No. 4007

P. O. Address_____

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.