SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 FILED OCT 26 1961 Primary Registration District No. 1003 Registrar's No. 9725 STATE FILE NUMBER -61-039423

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST.LOUIS CITY HOSP. #1. — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY

c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 2040a GEYER — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First WILHELMINA Middle ZANONE Last

4. DATE OF DEATH: Month OCT. Day 20, Year 1961

5. SEX: Female

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: Nov. 24 1876

9. AGE (last birthday): 84 — 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): TABACCO STRIPPER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Mo

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: JAMES P. HOSTMARK

13b. MOTHER'S MAIDEN NAME: SARAH ROGAN

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: LORETTA TRISKA Address: 2040a GEYER

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE

DUE TO (c): 4200

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): CEREBRAL EMBOLUS

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? 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 10/11/61 5A.M, to 10/20/61 and last saw her/him alive on 10/20/61

Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. E. [signature] M.D.

22b. ADDRESS: 1515 LAFAYETTE AVE

22c. DATE SIGNED: 10/20/61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: OCT. 23 1961

23c. NAME OF CEMETERY OR CREMATORY: CALVARY CEM.

23d. LOCATION (City, town, or county): ST. LOUIS (State): Mo

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: OCT 21 1961

26. REGISTRAR'S SIGNATURE: Carl Smith. M.D.

DATE AMENDED 9-

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Eleuan Provinie

Licensed Embalmer No. 3 to 3

P. O. Address 2906 Gran

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