SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-046173

MENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11513 STATE FILE NUMBER

FILED DEC 18 1961

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

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

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Anthony Hospital — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 6202 Rhodes Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Last CHLANDA

4. DATE OF DEATH Month Dec. Day 8 Year 1961

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 1-15-1886

9. AGE (last birthday) 75 — 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) St. Louis, Mo.

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

13a. FATHER'S NAME William Tureczek

13b. MOTHER'S MAIDEN NAME Veronica Worker

14. NAME OF HUSBAND OR WIFE Late William F. Chlanda

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 William Chlanda Address #43 Dorclin Lane(28)

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) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH 6 months

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

DUE TO (b) Diabetes Coma — 24 hrs.

DUE TO (c) 260+

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 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 June 8 61, to Dec 8 61 and last saw her ~~him~~ alive on Dec 8 61

Death occurred at 7:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John D Sert M.D.

22b. ADDRESS 3739 Grains

22c. DATE SIGNED 12 11 61

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

23b. DATE Dec. 12, 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. DEC 11 1961

26. REGISTRAR'S SIGNATURE Carl 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. Storrsand

Licensed Embalmer No. 4007

P. O. Address St. Louis

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.