MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-029164
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7508

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED 7 26

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF DOCUMENT

FILED AUG 6 1962

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): INCARNATE WORD HOSP
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): 3130 a MAGNOLIA
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First MARY Middle Last SHALTZ

4. DATE OF DEATH: Month JULY Day 30 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐

8. DATE OF BIRTH: JULY 4 1898

9. AGE (last birthday): 64

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): SEAMSTRESS

10b. KIND OF BUSINESS OR INDUSTRY: CHAPMAN CLEANING CO

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

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

13a. FATHER'S NAME: UNKNOWN

13b. MOTHER'S MAIDEN NAME: UNKNOWN

14. NAME OF HUSBAND OR WIFE: MARTIN SHALTZ

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: JOSEPH SHALTZ Address: 2455 CECELIA

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): Cancer of colon
INTERVAL BETWEEN ONSET AND DEATH: Mar 1962
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 153.0

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 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 3/21 to 7/30 and last saw her/him alive on 7/30
Death occurred at 830 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Ralph Berg (Degree or title) MD

22b. ADDRESS: 3203 S Grand

22c. DATE SIGNED: 7/31/62

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

23b. DATE: AUG 2 1962

23c. NAME OF CEMETERY OR CREMATORY: ST. PETER + PAUL 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.: JUL 31 1962

26. REGISTRAR'S SIGNATURE: Hoard 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 Eleanor Rovince

Licensed Embalmer No. 3403

P. O. Address 2906 Grooms

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.