

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032976

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8429

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

FILED SEP 10 1962		1. PLACE OF DEATH (Where deceased lived. If institution: Residence before admission)	
a. COUNTY ST. LOUIS, MISSOURI		b. CITY OR TOWN St Louis	
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		d. STREET ADDRESS (If outside, give location) 824 Lafayette Ave	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First PETE Middle NN Last TOMICH		Month AUGUST Day 27 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/12/04
10a. USUAL OCCUPATION (Give kind of work done during most of work's life, even if retired) Warehouseman		10b. KIND OF BUSINESS OR INDUSTRY Sears	11. BIRTHPLACE (City and state or country) Jugoslavia
13a. FATHER'S NAME Sam Tomich		13b. MOTHER'S MAIDEN NAME Angeline Maravich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Anna Tomich		Address 824 Lafayette Ave	
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) CARCINOMA OF LUNG WITH METASTASES			6 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b)			
DUE TO (c) 163x			
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.
ANEMIA SECONDARY TO IRRADIATION			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>
20c. TIME OF INJURY	Hour	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
21. I attended the deceased from JULY 23, 1962 to AUG. 27, 1962 and last saw her alive on AUG. 27, 1962		Death occurred at 10:20 A on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>[Signature]</i> (Degree or title) M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 8/27/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/30/62	23c. NAME OF CEMETERY OR CREMATORY Mt Hope Cemetery	23d. LOCATION (City, town, or county) (State) St Louis County Mo
24. FUNERAL DIRECTOR Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. AUG 30 1962	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE BLACK INK OR TYPEWRITER RIBBON

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 Hadley R. Jaeller Jr

Licensed Embalmer No. 1950

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.