

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043939

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11250

FILED DEC 5 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair,		c. CITY OR TOWN E. St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 756 N. 76th St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First LEO Middle L. LOUIS Last BASTIAN			4. DATE OF DEATH Month NOVEMBER Day 21 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 9-12-1893		9. AGE (last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Officer		10b. KIND OF BUSINESS OR INDUSTRY Ill. Vet. Com.		11. BIRTHPLACE (City and state or country) E. St. Louis, Ill		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME Isadore Bastian			13b. MOTHER'S MAIDEN NAME Patrina Engert			14. NAME OF HUSBAND OR WIFE Clara J. (Wuelling)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W. W. #1		16. SOCIAL SECURITY NO. W. W. #1		17. INFORMANT Mrs. Clara Bastian		Address 756 N. 76th St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHO SARCOMA								INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								2001			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) BRONCHOPNEUMONIA, BILATERAL.								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		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 <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 MAY 24, 1962 to NOV. 21, 1962 and last saw her alive on NOVEMBER 21, 1962				Death occurred at 11:55pm on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>James F. Michel</i> (Degree or title) M.D.				22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 11/23/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-25-1962		23c. NAME OF CEMETERY OR CREMATORY St. Clair Memorial Park		23d. LOCATION (City, town, or county) E. St. Louis, Ill.		(State)			
24. FUNERAL DIRECTOR C. G. Kurrus		ADDRESS E. St. Louis, Ill.		DATE NOV 23 1962		REG. NO. 11250		26. REGISTRAR'S SIGNATURE <i>Head Smith, M.D.</i>			

STATE OF MISSOURI

DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

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. G. Kurrang*

Licensed Embalmer No. 3162

P. O. Address East St. Louis Ill

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.