

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026412

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7033**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

FILED JUL 12 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Missouri b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7823 Minnesota Ave		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 7823 Minnesota Ave		d. STREET ADDRESS (If outside, give location) 7823 Minnesota Ave Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Oscar W. Soutiea			4. DATE OF DEATH Month Day Year July 4 1963
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 12-9-1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) 71 Yrs
11. BIRTHPLACE (City and state or country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME August Soutiea		13b. MOTHER'S MAIDEN NAME Elizabeth Gerlach	
14. NAME OF HUSBAND OR WIFE Eugenia		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 Address Eugenia Soutiea 7823 Minnesota Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute dilatation of heart			INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) generalized Ca metastasis			several months
DUE TO (c) Cancer of pancreas			1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 157x			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 type="checkbox"/> NO <input checked="" 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 1959 , to _____, and last saw ^{her} him alive on 7-4-63 . Death occurred at 11:58 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Louis D. Crochard M.D.		22b. ADDRESS 75x Lemay Ferry Rd	
22c. DATE SIGNED 7/5/63		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-8-1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	
23d. LOCATION (City, town, or county) Lemay (25) Mo		23e. REGISTERAR'S SIGNATURE Road Smith, M.D.	
24. FUNERAL DIRECTOR ADDRESS Fendler Und. Co 7420 Michigan Ave		25. DATE RECD. BY LOCAL REG. JUL 6 1963	

Dr. Crecelius

6 4111 8:30

0-09

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

W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Michigan

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.