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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 3 1945

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 4154

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1475

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3627 Lawn
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 17

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL") 14

(d) Street No. 3627 Lawn
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lillie M. Doubek

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank J. Doubek

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Mar. (Month) 26 (Day) 1883 (Year)

8. AGE: Years 61 Months 10 Days 17 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Sykora
13. Birthplace (City, town, or county) Bohemia (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Bohemia (State or foreign country)

16. (a) Informant Frank J. Doubek
(b) Address 3627 Lawn

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Old S.S. Peter & Paul

18. (a) Signature of funeral director Thos. Kutis & Son
(b) Address 2906 Gravois

19. (a) FEB 14 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 12
year 1945 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from Jan. 10, 1936, to Feb. 12, 1945, that I last saw her alive on Feb. 12, 1945, and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Uraemic Poisoning | 3 days |
| Due to Diabetes Mellitus | 16 yrs. |
| Myocarditis Chr | 3 yrs. |
| Due to Coronary disease | 2 yrs. |
| Auricular Fibrillation | 6 mos. |
| Other conditions (Include pregnancy within 3 months of death) Nephritis Glomerular | 4 yrs. |

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? No (Specify type of place)
While at work (e) Means of injury

23. Signature John D. Steel M.D. (M. D. or other) M.D.
Address 2767 Gravois Ave. Date signed 2-13-45

(Licensed Embalmer's Statement on Reverse Side)

## 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 .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed David Van Fossen

Licensed Embalmer No. 4242

P. O. Address 2906 Grand

**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 this body is not embalmed, fact should be so stated above.**