

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH21663  
State File No. 5037  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. <u>1003</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Gas</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) <u>0</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		17 <sup>a</sup>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CITY HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>16-4120A WYOMING ST.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>BARBARA</u> b. (Middle) <u>KATHRINE</u> c. (Last) <u>SEDAK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 8-1949</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>	8. DATE OF BIRTH <u>NOV. 26-1870</u>	9. AGE (In years last birthday) <u>78</u> YRS.	IF UNDER 1 YEAR Days _____	IF UNDER 4 HRS. Hours _____	Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIL</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>PRAGUE-YUGO-SLAVIA</u>		12. CITIZENRY OF WHAT COUNTRY? <u>D.S.A.</u>		
13a. FATHER'S NAME <u>JOSEPH VONDRICH</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mildred Mrazek</u> ADDRESS <u>4120 Wyoming</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fracture of right hip; Atherosclerosis. when she slipped and fell to the floor at her home on May 28 1949</u> DUE TO (b) <u>accident</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Accident</u>					INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis Mo / 86</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>July 28 49 7:00 p.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>18</u>				
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:55 P. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Edmund E. Snyder 3</u>			23b. ADDRESS <u>1300 Clark Ave</u>		23c. DATE SIGNED <u>6/8/49</u>			
24a. BURIAL, CREMATION, OR OTHER REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JUNE 11-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SUN SET BURIAL PK.</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>J. B. Saratan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schurer</u>		ADDRESS <u>3125 Lafayette</u>				

(Licensed Embalmer's Statement (on Reverse Side))

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

**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 .....  
Student Embalmer

Signed

*John B. Williams*

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette*

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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