

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21754

State File No.

FILED JUL 15 1949

BIRTH NO. # 96946

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 5752

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY over	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. (1)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital # 1		d. STREET ADDRESS (If rural, give location) 23- 1110 Lafayette Av	

3. NAME OF DECEASED (Type or Print) ANNA	a. (First)	b. (Middle)	c. (Last) SURAN	4. DATE OF DEATH July 2nd, 1949	(Month) (Day) (Year)
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH About 1870	9. AGE (In years last birthday) Abt 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 11 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Czechoslovakia 6	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME Charles Maroanik	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Frank
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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 ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arterio Sclerosis DUE TO (c) Osteitis deformans, (Paget's disease) generalized		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 97
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4500
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22. I hereby certify that I attended the deceased from 4/24, 1949, to 7/2, 1949, that I last saw the deceased alive on 7/2, 1949, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Charles Maroanik	(Degree or title) M.D.	23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 7/2/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/5/49	24c. NAME OF CEMETERY OR CREMATORY S S Peter & Paul Cem	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. JUL 3 1949	REGISTRAR'S SIGNATURE J.B. Sasser	25. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Woychick	ADDRESS 1926 Allen Av
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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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Benny J. Duncan

Licensed Embalmer No.

2272

P. O. Address

1926 Allen

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.