

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31782**
8330

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		e. STREET ADDRESS (If not in institution, give street address or location) 1836 1/2 South 12th St.		
3. NAME OF DECEASED (Type or Print) a. (First) Kathica b. (Middle) _____ c. (Last) Georgevich			4. DATE OF DEATH (Month) (Day) (Year) Sept 26 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 11 1866	
9. AGE (in years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Jugoslavia
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? U S
13a. FATHER'S NAME Nikifor Bosiock		13b. MOTHER'S MAIDEN NAME Natalia ?		14. NAME OF HUSBAND OR WIFE George (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME George Georgevich ADDRESS 1836 s 12th Stre
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture Right Hip arterio sclerosis secured DUE TO (b) when deceased fell in his home at 1848 S 12th DUE TO (c) on Sept 18 1949 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Accident		INTERVAL BETWEEN ONSET AND DEATH 67 1/2 71
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo 186
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 18 49 m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 18 6-900
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 5:35 P.m. , from the causes and on the date stated above.				
23a. SIGNATURE Cathie E. Taylor (Degree or title) Corl		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 9-27-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/29/49		24c. NAME OF CEMETERY OR CREMATORY Mt Hope Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Fun Home ADDRESS 1926 Allen		
DATE REC'D BY LOCAL REG. SEP 27 1949		REGISTRAR'S SIGNATURE J. B. Lassater		

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 John Strammann

Licensed Embalmer No. 4533

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.