

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38582
State File No. 9753

1003

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3766 Robert</u>		d. STREET ADDRESS (If rural, give location) <u>3766 Robert</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) c. (Last) <u>Chaloupecky</u>			4. DATE OF DEATH <u>Nov. 10 1949</u> (Month) (Day) (Year)					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 13 1870</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Bohemia</u>		12. CITIZEN OF WHAT COUNTRY?		

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mary</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>Mary Chaloupecky</u>		ADDRESS <u>3766 Robert</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				<u>8 days</u>	
		ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>					
		DUE TO (c) <u>Arterio Sclerosis</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Frailty</u>					

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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>97</u>			
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? <u>B3IX</u>			

22. I hereby certify that I attended the deceased from Aug, 1947, to Nov 10, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:03P AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ann Knall, M.D.</u>		23b. ADDRESS <u>2416 W. Grand</u>		23c. DATE SIGNED <u>11/12/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-14-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Picker</u>	
		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>			

DATE REC'D BY LOCAL REG. <u>NOV 12 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Proater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. P. Fendler Jr.</u>		ADDRESS <u>7128 Michigan</u>	
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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

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Clarence Polchow

Licensed Embalmer No. 3093

P. O. Address 7128 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 this body is not embalmed, fact should be so stated above.