

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **39342**
9647

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		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 Missouri b. COUNTY Mad				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Missouri		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		17		
d. FULL NAME OF HOSPITAL OR INSTITUTION 1217 a Geyer Av				d. STREET ADDRESS (If rural, give location) 23 - 1217 a Geyer Av				
3. NAME OF DECEASED (Type or Print) Jerry			a. (First)		b. (Middle) Suchy		c. (Last)	
4. DATE OF DEATH		(Month) Nov		(Day) 6		(Year) 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 30 1891		
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months		IF UNDER 2 YEAR Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY Leather			11. BIRTHPLACE (State or foreign country) Czechoslovakia 6		
12. CITIZEN OF WHAT COUNTRY? U S								
13a. FATHER'S NAME Frank Suchy			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Josephine Suchy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josephine Suchy 1217a Geyer Av				
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) Carcinoma of Esophagus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 6 Months	
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) St Louis MO				
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? 16' X				
22. I hereby certify that I attended the deceased from Oct 14 , 1949, to Nov 6 , 1949, that I last saw the deceased alive on Nov 6 , 1949, and that death occurred about 11:30 m., from the causes and on the date stated above.								
23a. SIGNATURE Phillard J. Nash			(Degree or title) D.A.		23b. ADDRESS 1829 518 St Louis 4 MO		23c. DATE SIGNED 11/9/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/9/49		24c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Missouri		
DATE REC'D BY LOCAL REG. NOV 8 1949		REGISTRAR'S SIGNATURE J. B. Fasaler			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Maryell Funeral Home 1926 Allen Av			

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

Del A. 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.