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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25130

FILED AUG 10 1950

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6503**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>City St. Louis</b>		c. LENGTH OF STAY (in this place) <b>8/4/50 / 7/24/50</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Infirmiry Hospital.</b>		d. STREET ADDRESS (If rural, give location) <b>4054 Lafayette Av</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Prokop</b>		b. (Middle)		c. (Last) <b>Pavlicek.</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>July 4 1873</b>	
13a. FATHER'S NAME <b>Joseph Pavlicek</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Rose (Deceased)</b>	
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.		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>	
19. 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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>33 days</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____ DUE TO (c) <b>Arteriosclerotic heart disease</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>H2O</b>	
22. I hereby certify that I attended the deceased from <b>July</b> , 19 <b>47</b> , to <b>July</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 25</b> , 19 <b>50</b> , and that death occurred at <b>1:15 a.</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>John Eshen Kirk, M.D. Acting medical director</b>		23b. ADDRESS <b>5349 Vernon Av. St. Louis</b>		23c. DATE SIGNED <b>7/28/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24b. DATE <b>7/31/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>	
DATE REC'D BY LOCAL REG. <b>JUL 30 1950</b>		REGISTRAR'S SIGNATURE <b>J.P. Locater</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis Mo.</b>	
		25. FUNERAL DIRECTOR'S SIGNATURE <b>Impact Funeral Home</b>		ADDRESS <b>1926 Allen Av</b>	

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

working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No. ....

Signed Dale A. Johnson

Licensed Embalmer No. 4533

P. O. Address 1956 Allen

**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.