

FILED SEP 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28196

Registrar's No. 7229

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7229</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2239</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1757 Preston Pl</b>				d. STREET ADDRESS (If rural, give location) <b>23 1757 Preston Pl</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Frank</b>		b. (Middle) _____		c. (Last) <b>Gajdosik Sr</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>8 23 50</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>7-20-1881</b>		9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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 _____		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZENRY OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>John Gajdosik</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Frances Gajdosik</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Frances Gajdosik 1757 Preston Pl</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>arteriosclerosis</b>  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 <b>1 week</b>  <b>15 yrs.</b>	
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>fall</b>			
22. I hereby certify that I attended the deceased from <b>Aug 17, 1950</b> , to <b>Aug 23, 1950</b> , that I last saw the deceased alive on <b>Aug 23, 1950</b> , and that death occurred at <b>11:45 a. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Edward H. Hamer M.D.</b>				23b. ADDRESS <b>1504 So Grand</b>		23c. DATE SIGNED <b>8/24/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-26-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Old St. Peter &amp; Paul</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>	
DATE REG'D BY LOCAL REGISTRAR'S SIGNATURE <b>AUG 25 1950</b> <b>J. B. Sabater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Moydell Funeral Home 1926 Allen</b>					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*See*

**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 Dale A. Traumann

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.