

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13818**
3268

BIRTH NO. **24005-57** 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 M. S. O. U. R. I. b. COUNTY	
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	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 1359 KRAFT Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		3. NAME OF DECEASED (Type or Print) a. (First) Bobby b. (Middle) Infant c. (Last) Bozesky	
4. DATE OF DEATH (Month) (Day) (Year) April 5, 1951		5. SEX M	
6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S	
8. DATE OF BIRTH April 4, 1951		9. AGE (In years last birthday) IF UNDER 1 YEAR Days IF UNDER 24 HRS. Hours Min. - - 1 -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Edward Bozesky		13b. MOTHER'S MAIDEN NAME Anna Moran	
14. NAME OF HUSBAND OR WIFE		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 ADDRESS Edward Bozesky 1359 Kraft Str.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital tachycardia ANTECEDENT CAUSES Esophageal fistula 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.	
19a. DATE OF OPERATION 4/6/51		19b. MAJOR FINDINGS OF OPERATION Consistent above.	
20. AUTOPSY? YES <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 759.0		22. I hereby certify that I attended the deceased from 4/4 , 19 51 , to 4/5 , 19 51 , that I last saw the deceased alive on 4/5 , 19 51 , and that death occurred at 4:30 a.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) James L. Miller M.D.		23b. ADDRESS 6342 Grand	
23c. DATE SIGNED 4/6/51		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 4-7-51		24c. NAME OF CEMETERY OR CREMATORY Resurrection	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin 3301 Lafayette	
DATE REC'D BY LOCAL REG. APR 7 1951		REGISTRAR'S SIGNATURE J. B. Laster	

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 _____

working under my personal supervision. *Not Embalmed* Student Embalmer No. *J. Y. Farris*

Student _____
Student Embalmer

Signed *Thomas H. Lockley*

3384
Licensed Embalmer No. *General Director*

P. O. Address *2301 Lafayette Ave*

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.