

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35796

8798

FILED OCT 23 1951

State File No.
Registrar's No.

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo 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 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION Marion Hosp		e. STREET ADDRESS (If rural, give location) 2344 So 18th St	

3. NAME OF DECEASED (Type or Print) a. (First) Peter b. (Middle) c. (Last) ZACAR		4. DATE OF DEATH (Month) (Day) (Year) 10 3 51	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 6-29-1891
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Jugoslavia Y
12. CITIZEN OF WHAT COUNTRY? U.S.			

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Single
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Thomas Grbac	ADDRESS 2346 So 18th St
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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		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) GASTRIC ULCER		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) WITH PERFORATION		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. MESENTERIC THROMBOSIS		1 DAY	

19a. DATE OF OPERATION 9-29-51	19b. MAJOR FINDINGS OF OPERATION PERFORATED GASTRIC ULCER	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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? 5401

22. I hereby certify that I attended the deceased from **9-1-1948**, to **10-3-1951**, that I last saw the deceased alive on **10-2-1951**, and that death occurred at **4:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE O. H. Jones	(Degree or title) M.D.	23b. ADDRESS 3616 S. Bolwy, St Louis	23c. DATE SIGNED 10-3-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-8-51	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE RECD BY LOCAL REG. OCT 5 1951	REGISTRAR'S SIGNATURE J. Paul Smith	25. FUNERAL DIRECTOR'S SIGNATURE W. J. ...	ADDRESS Moydell Funeral Home 1926 Allen
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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 me

working under my personal supervision.

Signed George J. Luskada Jr.
Student Embalmer

Signed John A. Hanuman

Student Embalmer No. 421
Licensed Embalmer No. 4533

P. O. Address St. Louis, Mo.

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.