

FILED JAN 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43365

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** State File No. **11683** Registrar's No. **11683**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri	b. COUNTY 2154
c. LENGTH OF STAY (In this place)		5. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 4110 Oregon Ave.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Judith	b. (Middle) Marie	c. (Last) Svoboda	(Month) December	(Day) 30	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH December 1, 1940		9. AGE (In years last birthday) 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph A. Svoboda	13b. MOTHER'S MAIDEN NAME Anna E. Trinstetic	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Joseph A. Svoboda	ADDRESS 4110 Oregon Ave.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pneumonia Acute		INTERVAL BETWEEN ONSET AND DEATH
	INTERCURRENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Edema		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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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? 525-X
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22. I hereby certify that I attended the deceased from **12-30-51**, 19**51**, to **12-30**, 19**51**, that I last saw the deceased alive on **12-30**, 19**51**, and that death occurred at **11:30A.m.**, from the causes and on the date stated above.

23a. SIGNATURE Carl S. Tetich M.D.	(Degree or title)	23b. ADDRESS 3284 Ivanhoe	23c. DATE SIGNED 12-31-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan. 2, 1952	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. DEC 31 1951	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Gebken-Benz Mortuary	ADDRESS 2842 Meramec St.
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(Licensed Embalmer's Statement on Reverse Side) **St. Louis 18 Mo.**

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed

Loren B. Percy

Licensed Embalmer No. 4094

P. O. Address 2842 Meramec St.
St. Louis 18 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.