

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14796**
Registrar's No. **3896**

MAY 1 - 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri 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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 1217 Soulard Street	

3. NAME OF DECEASED a. (First) Theresa b. (Middle) c. (Last) Slonski			4. DATE OF DEATH (Month) (Day) (Year) April 24 1952		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Nov 9 1873		9. AGE (In years last birthday) 78		10. UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U S		13a. FATHER'S NAME Joseph Kraft		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Michael Slonski		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Michael Slonski		ADDRESS 1217 Soulard Street			

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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis DUE TO (c) cardiac decompensation				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 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? 4201					

22. I hereby certify that I attended the deceased from **Mar 27, 1952** to **Apr 24, 1952**, that I last saw the deceased alive on **Apr 23, 1952**, and that death occurred at **2:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E H Kellner MD		23b. ADDRESS 3131 Grand		23c. DATE SIGNED 4-25-52	
--	--	--------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 4/26/52		24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory		24d. LOCATION (City, town, or county) (State) St Louis Missouri.	
DATE REC'D BY LOCAL REG. APR 25 1952		REGISTRAR'S SIGNATURE Carly Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen Av			

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

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed

Dale A. Shannon

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.