No. 300
10-48

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

FILED JAN 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3333

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0200

1. PLACE OF DEATH
a. COUNTY /
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis Mo
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1822 Cass ave

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY
c. CITY OR TOWN St Louis Mo
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 1822 Cass ave 2219 0
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3. NAME OF DECEASED (Type or Print)
a. (First) Mary Ann
b. (Middle)
c. (Last) Tabaka

4. DATE OF DEATH (Month) 1- (Day) 8-54 (Year)

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH 3-30-86
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY *****
11. BIRTHPLACE (City and State or Foreign Country) Poland 4
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Deceased

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 Mary Gorzel ADDRESS 4933a Geraldine

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Occlusion
DUE TO (c) Arteriosclerosis

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 ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4201

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 430 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Wm G Perry Deputy Coron
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 1/9/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1/11/54
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) (State) St Louis Mo

DATE REC'D BY LOCAL REG. JAN 9 1954
REGISTRAR'S SIGNATURE J. Earl Smith, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Central Funeral Home ADDRESS 1841 Cass

S.P. (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, ~~or by~~ ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Elton R. H. Remehiss

Licensed Embalmer No. 42

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.