

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6623

State File No.

FILED MAR 8 1954

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1631

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS, MO.</u>				c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>ST. LOUIS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Pacific Hospital</u>				STREET ADDRESS (If rural, give location) <u>6 4703 St. Louis Ave.</u>							
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)		
<u>JOSEPH</u>							<u>NOGRADY.</u>		<u>2-18-54</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JUNE-11-1884</u>		9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Hungary</u>			12. CITIZEN OF WHAT COUNTRY? <u>8</u>		
13a. FATHER'S NAME <u>Joseph Nogrady</u>				13b. MOTHER'S MAIDEN NAME <u>Maria Delphia</u>				14. NAME OF HUSBAND OR WIFE <u>Susanna Nogrady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>490-02-1025</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Susanna Nogrady</u>				ADDRESS <u>4703 St. Louis</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension Heart Disease</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 1/2 years</u> <u>14 "</u>	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>443X</u>							
22. I hereby certify that I attended the deceased from <u>1-18</u> , 19 <u>54</u> , to <u>2-18</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>54</u> , and that death occurred at <u>11:25 a.m.</u> , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <u>August H. White, M.D.</u>						23b. ADDRESS <u>Two Pal House - St. Louis</u>			23c. DATE SIGNED <u>Feb. 18, 1954</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-20/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u>			24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>				
DATE REC'D BY LOCAL REG. <u>FEB 19 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sullivan's 2849 N. Euclid Ave.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Albert Mayfield*
Licensed Embalmer No. *30*

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.