

FILED JUL 26 1954

STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 24241

Registrar's No. 6414

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 Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION Old Faith Hospital			d. STREET ADDRESS (If rural, give location) 23 2842 Lafayette Av		
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle) Magdalen	c. (Last) Bartnikaitis	4. DATE OF DEATH (Month) (Day) (Year) July 13 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 16 1883	9. AGE (In years last birthday) 70	IF 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 (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE John (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Joseph Bartnikaitis			
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.	18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Hypertensive Cardio-Vascular Disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive Nephrosclerosis				INTERVAL BETWEEN ONSET AND DEATH 5 Days 10 yrs 2 yrs
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? 443X				
22. I hereby certify that I attended the deceased from April 1954 1948, to July 13, 1954, that I last saw the deceased alive on 7/13, 1954, and that death occurred at 4:50 P. M., from the causes and on the date stated above.					
23a. SIGNATURE John J. Shortland (Degree or title) M.D.			23b. ADDRESS 3720 Washington St.		23c. DATE SIGNED 7/16/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/16/54	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. Jul 15 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home 1926 Allen Av		

(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
Student Embalmer

Signed Reinhold K. Lohman

Licensed Embalmer No. 3395

P. O. Address St. Louis 4 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.