

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25303

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6263

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 OR TOWN St Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony's Hospital		• STREET ADDRESS (If rural, give location) 23 2754 Armand Place 22390	

3. NAME OF DECEASED (Type or Print) a. (First) Marie b. (Middle) Cecelia c. (Last) Stupka		4. DATE OF DEATH (Month) (Day) (Year) July 9 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov 21 1878
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Matthew Castalik	13b. MOTHER'S MAIDEN NAME Anna Shura	14. NAME OF HUSBAND OR WIFE Frank (Deceased)
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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 ADDRESS Frank Stupka 2754 Armand Place
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 2/28/54	19b. MAJOR FINDINGS OF OPERATION Carcinoma of stomach inoperable	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (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? 151X

22. I hereby certify that I attended the deceased from June 20, 1954, to July 9, 1954 that I last saw the deceased alive on July 9, 1954, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Benjamin I. Hirsch</i>	23b. ADDRESS 634 No Grand	23c. DATE SIGNED 7/13/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/13/54	24c. NAME OF CEMETERY OR CREMATORY S S eter & Paul Cem
24d. LOCATION (City, town, or county) (State) St Louis Missouri		

DATE REC'D BY LOCAL REG. JUL 12 1954	REGISTRAR'S SIGNATURE <i>Charles Smith MD</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home, 1926 Allen Av
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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 *Reinhold W. Lohme*

Licensed Embalmer No. *339*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.