

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29131**
Registrar's No. **7566**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7566			
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. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION. ST. LOUIS CITY HOSPITAL				e. STREET ADDRESS (If rural, give location) 2169 16 3419 TENNESSEE					
3. NAME OF DECEASED (Type or Print) a. (First) BARBARA			b. (Middle) _____		c. (Last) NOSKA		4. DATE OF DEATH (Month) (Day) (Year) AUGUST 14, 1954		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH JULY 8 1866			
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Missouri			
13a. FATHER'S NAME ALBERT GREZNA			13b. MOTHER'S MAIDEN NAME BARBARA HRUBY		14. NAME OF HUSBAND OR WIFE THOMAS NOSKA (DEC'D)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS GEORGE NOSKA 3419 TENNESSEE					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Terminal bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 334X					
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? _____					
22. I hereby certify that I attended the deceased from 8-4-54 , 19____, to 8-14-54 , 19____, that I last saw the deceased alive on 8-14-54 , 19____, and that death occurred at 2:15P m., from the causes and on the date stated above.									
23a. SIGNATURE Joseph A. Ess M.D. (Degree or title)				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 8-16-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE AUG 17 1954		24c. NAME OF CEMETERY OR CREMATORY S. S. PETER & PAUL		24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo			
DATE REC'D BY LOCAL REG. AUG 16 1954		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Geavies					

G.P. (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 *Lowell C. Hill*.....

Licensed Embalmer No. *43479*.....

P. O. Address *2906 St. ...*.....

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.