

FILED NOV 22 1954

STANDARD CERTIFICATE OF DEATH

39381
State File No.
Registrar's No. 10154

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros Hospital		d. STREET ADDRESS (If rural, give location) 3231a Oregon Av	
3. NAME OF DECEASED (Type or Print) August		4. DATE OF DEATH (Month) (Day) (Year) Nov 6 1954	
a. (First)		b. (Middle) O	
c. (Last) Wondracek			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 2 1876
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist	11. BIRTHPLACE (State or foreign country) St Louis Missouri
12. CITIZEN OF WHAT COUNTRY? U S A			
13a. FATHER'S NAME Frank Wondracek		13b. MOTHER'S MAIDEN NAME Mary Stak	
14. NAME OF HUSBAND OR WIFE Josephine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Josephine Wondracek		ADDRESS 3231a Oregon Av	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-sclerotic heart disease ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 months	
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 <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 4200	

22. I hereby certify that I attended the deceased from Oct 26, 1954, to Nov 6, 1954, that I last saw the deceased alive on Nov 6, 1954, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE John Deuland		23b. ADDRESS 2840 E California		23c. DATE SIGNED 11-8-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/9/54		24c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery	
				24d. LOCATION (City, town; or county) St Louis, Missouri	

DATE REC'D BY LOCAL REG. NOV 9 1954		REGISTRAR'S SIGNATURE Charles Smith MD		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
Student Embalmer

Signed *Renehold K. Lohmann*

Licensed Embalmer No. *3395*

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