

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3274**
Registrar's No. **0983**

FILED FEB 14 1955

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 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 type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 6159 McPherson Avenue		e. STREET ADDRESS (If rural, give location) 5 6159 McPherson Avenue.	

3. NAME OF DECEASED (Type or Print) MARIA	a. (First)	b. (Middle)	c. (Last) ZICH	4. DATE OF DEATH (Month) (Day) (Year) Jan. 31, 1955
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 24, 1892	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and State or Foreign Country) Russia	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Jacob Grzyb	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE John Zich 6
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 ADDRESS John Zich 6159 McPherson Ave.

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		MEDICAL CERTIFICATION Myocardial Infarction	INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease			
	DUE TO (c)			
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 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)
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? 443X

22. I hereby certify that I attended the deceased from **Jan 10, 1955**, to **Jan 31, 1955**, that I last saw the deceased alive on **Jan 24, 1955**, and that death occurred at **6:45** m., from the causes and on the date stated above.

23a. SIGNATURE Edward W. Geburki M.D.	(Degree or title)	23b. ADDRESS 3701 Grand St	23c. DATE SIGNED 2/2/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/3/55	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) S. Louis, Mo.
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DATE REC'D BY LOCAL REG. FEB 2 1955	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John Stygar & Son 5541 Riverview Blvd.
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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..... *J. M. Pister*

Licensed Embalmer No. *3980*

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.