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FILED SEP 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31825

BIRTH NO. 47192-55 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 2028

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rock Hill Mo</u>		c. CITY OR TOWN <u>Crestwood</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>23 days</u>		e. STREET ADDRESS (If rural, give location) <u>778 Denton Court</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Marys Hosp</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>NICKOLAS</u> c. (Last) <u>ANDJELICH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 30 1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>July 10 - 1955</u>	9. AGE (In years last birthday) <u>1</u>	10. UNDER 1 YEAR <u>1</u> MONTHS <u>20</u> DAYS <u>0</u> HOURS <u>0</u> MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Rock Hill Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>Nickola Andjelich</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Suedel</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Nickola Andjelich</u>	ADDRESS <u>778 Denton Court</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>46 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastric enteritis, acute</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>new born - coughs</u> 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 <u>5710</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) (Minute)	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 July 10, 1955, to Aug 30, 1955, that I last saw the deceased alive on Aug 30, 1955, and that death occurred at 7:30 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Coedner K. Hammet M.D.</u>	23b. ADDRESS <u>35 W Central Clayton</u>	23c. DATE SIGNED <u>8/30/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>Aug 30 - 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>	24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>
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DATE REC'D BY LOCAL REG. <u>8/30/55</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donk M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W H Johnson</u>	ADDRESS <u>6536 Clayton Rd</u>
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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 *Not Embalmed*
W. H. Johnson
Licensed Embalmer No.....

P. O. Address

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.