

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35207

State File No. _____

FILED OCT 24 1955

8663

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

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: Enroute City Hospital		e. STREET ADDRESS (If rural, give location) 24 3016 Cherokee Street	

3. NAME OF DECEASED (Type or Print)	a. (First) George	b. (Middle) Jura j	c. (Last) Struharik	4. DATE OF DEATH (Month) (Day) (Year) Oct 2 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 25 1893	9. AGE (In years last birthday) 61	# UNDER 1 YEAR Months	# UNDER 10 HRS. Hours	# UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tuckpointer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Martin Struharik	13b. MOTHER'S MAIDEN NAME Katherine Fusco	14. NAME OF HUSBAND OR WIFE Katherine
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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 Katherine Struharik	ADDRESS 3016 Cherokee St
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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, asthma, 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) Cancer of Colon		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis 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 153x	20. AUTOPSY? YES <input 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)
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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?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **229A** m., from the causes and on the date stated above.

22a. SIGNATURE James M. Keely Deputy Registrar	(Degree or title)	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 10.4.55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/5/55	24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Missouri.
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DATE REC'D BY LOCAL REG. OCT 4 1955	REGISTRAR'S SIGNATURE J. Carl Smith Mo	25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home	ADDRESS 1926 Allen Av
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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 K. Lohmann*

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.