

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 23 1955

38132
State File No. 9998
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 38132		Registrar's No. 9998					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison									
b. CITY OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Granite City		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 Jewish Hospital				STREET ADDRESS (If rural, give location) 1813 Primrose									
3. NAME OF DECEASED (Type or Print) PAUL			a. (First)		b. (Middle)		c. (Last) CUVAR, JR		4. DATE OF DEATH (Month) (Day) (Year) 11 16 '55				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 7, 1903		9. AGE (In years last birthday) 51		IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (City and State or Foreign Country) Yugoslavia				12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Paul Cuvor, Sr.				13b. MOTHER'S MAIDEN NAME Susie Wesely				14. NAME OF HUSBAND OR WIFE Katherine Cuvor					
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. 333-03-0538		17. INFORMANT'S SIGNATURE OR NAME Katherine Cuvor ADDRESS Granite City, Illinois							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) HEPATIC COMA MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEPATIC COMA INTERVAL BETWEEN ONSET AND DEATH 7 DAYS *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CIRRHOSIS OF LIVER 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 581.0				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) _____		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 Oct 30 , 19 55 , to Nov 15 , 19 55 , that I last saw the deceased alive on Nov 15 , 19 55 , and that death occurred at 8 a. m. , from the causes and on the date stated above.													
23a. SIGNATURE Stan E. Holmes (Degree or title) M. D.				23b. ADDRESS Jewish Hospital, St. Louis				23c. DATE SIGNED Nov 16, 1955					
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-16-55		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Granite City, Illinois							
DATE REC'D BY LOCAL REG. NOV 16 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE John I. Sedlack ADDRESS Granite City, Illinois							

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 ^{NOT}embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John T. Sedlach*.....
Licensed Embalmer No. *374*.....

P. O. Address *Madison,*.....

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.