Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 26 1956

32293

STATE FILE NUMBER 8396

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3174 PENNSYLVANIA — Length of stay in 18 24

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3174 PENNSYLVANIA — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle NEDOMA Last
4. DATE OF DEATH Month SEPT Day 11 Year 1956
5. SEX Female
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH MAY 30 1883
9. AGE (In years last birthday) 73 — 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) WIDOW
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (City and state or country) BOHEMIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANK SLEZAK
14. MOTHER'S MAIDEN NAME UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT THERESA NEDOMA Address 3174 PENNSYLVANIA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombus — INTERVAL BETWEEN ONSET AND DEATH 24 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Advanced Arteriosclerosis — 20 yrs.
DUE TO (c) Chronic Nephritis — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1951, to Sept 11th 1956 and last saw her/him alive on Sept 10th 1956
Death occurred at 8 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Norman C. Edwards DO
22b. ADDRESS 8th W Big Bend Rd Webster Groves
22c. DATE SIGNED Sept 11 1956

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE SEPT 13 1956
23c. NAME OF CEMETERY OR CREMATORY S. S. PETER & PAUL
23d. LOCATION (City, town, or county) (State) ST. LOUIS MO

24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois
25. DATE RECD. BY LOCAL REG. SEP 11 1956
26. REGISTRAR'S SIGNATURE J Earl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed ....

Licensed Embalmer No. 434

P. O. Address 2506

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.