

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10821
STATE FILE NUMBER
1976

FILED MAR 18 1957

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

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHN'S Hosp. 23</u>		Length of stay in <u>2</u> days	d. STREET ADDRESS (If outside, give location) <u>5029 LOUISIANA</u>
3. NAME OF DECEASED (Type or print) <u>ANNA HNILICA-NILICA</u>		First Middle Last	4. DATE OF DEATH <u>FEB. 24 1957</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 26 1878</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIDOW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>BOHEMIA</u>
13. FATHER'S NAME <u>FRANK BACHRATI</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
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. <u>489-09-5849D</u>	17. INFORMANT <u>FRANK NILICA, Affton Mo</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC Hemorrhage</u> DUE TO (b) <u>CARCINOMA of Stomach</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerotic Cardiovascular Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>151X</u>
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>6 JAN 57</u> to <u>24 Feb 57</u> and last saw her alive on <u>23 Feb 57</u> Death occurred at <u>9:15 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John A. McClain M.D. D</u>		22b. ADDRESS <u>16 Hampton Village Plaza</u>	22c. DATE SIGNED <u>26 Feb 57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>FEB. 27 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S. S. PETER & PAUL CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
24. FUNERAL DIRECTOR <u>Thomas Kute 2906 Grand</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 27 '57</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, MD</u>

(Licensed Embalmer's Statement on Reverse Side)

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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 *James C. White*.....

Licensed Embalmer No. *434*.....

P. O. Address *2906*.....

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.