

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED SEP 4 1957

 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7602

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Length of stay in lb | | d. STREET ADDRESS <u>2141 5304 Delor St.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH EDWARD PROKES</u> | | | 4. DATE OF DEATH Month Day Year <u>AUGUST 13, 1957</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 9, 1899</u> |
| 9. AGE (In years last birthday) <u>57</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>Joseph J. Prokes</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Mares</u> | 14. NAME OF HUSBAND OR WIFE <u>Mary A. Prokes</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If none, give year or dates of service) <u>no none</u> | | 16. SOCIAL SECURITY NO. <u> </u> | 17. INFORMANT Address <u>Mary A. Prokes 5304 Delor St.,</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>CARCINOMA OF LARYNX WITH METASTASES TO NECK</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 Yrs.</u> |
| 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.) | |
| 20c. TIME OF INJURY a.m. Month, Day, Year p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION <u> </u> | COUNTY <u> </u> STATE <u> </u> |
| 21. I attended the deceased from <u>JUNE 28, 1957</u> to <u>AUG. 13, 1957</u> and last saw ^{her} _{him} alive on <u>AUG. 13, 1957</u> Death occurred at <u>6:45 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>C. Vermillion, M.D.</u> (Degree or title) | | 22b. ADDRESS <u>BARNES HOSPITAL</u> | 22c. DATE SIGNED <u>8/13/57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | 23b. DATE <u>8-16-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u> | 23d. LOCATION (City, town, or county) <u>St. Louis County Mo.</u> (State) |
| 24. FUNERAL DIRECTOR <u>Southern Funeral-Home</u> <u>6322 S. Grand, St. Louis, Mo.</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>AUG 14 57</u> | 26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>S. P.</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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



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.