

Dept. Health,
uc., & Welfare
U. S. Public
Health Service

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42648

STATE FILE NUMBER

318

1003

11227

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

V. S. 300
Rev. 1-57

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, give TOWNSHIP only) OR TOWN 915 N Grand St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 35 V. A. HOSPITAL		Length of stay in 1b 8 Days	STREET ADDRESS 52 5448 Holly Hills		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANK SRNKA			4. DATE OF DEATH Month Day Year 11/19/57		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/88		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCKMAN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME MATHEW SRNKA		13b. MOTHER'S MAIDEN NAME ANNA KOHOUT		14. NAME OF HUSBAND OR WIFE FLORENCE SRNKA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 495227528		17. INFORMANT Address V.A. HOSPITAL RECORDS ST. LOUIS, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS Arteriosclerosis of cerebral vessels Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH UNK UNK
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> NONE <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 Hour Month, Day, Year a.m. p.m.		-			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 COUNTY STATE	
21. Attended the deceased from Death occurred at 11/11/57 1:07 P.		to 11/19/57 and last saw him alive on 11/19/57		P. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Paul Smith</i> (Degree or title)		22b. ADDRESS M.D. VAH, ST. LOUIS, MISSOURI		22c. DATE SIGNED 11/19/57	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE NOV 23 1957		23c. NAME OF CEMETERY OR CREMATORY T. KAMINER, S. M. D. NEW PICKER, CEM.	
23d. LOCATION (City, town, or county) (State) ST. LOUIS MO		24. FUNERAL DIRECTOR Thomas Kates 2906 Travis		25. DATE RECD. BY LOCAL REG. NOV 22 57	
26. REGISTRAR'S SIGNATURE <i>Paul Smith</i>					

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Samuel Dill*

Licensed Embalmer No. *4342*

P. O. Address *2906 Harris*

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.