

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016649

STATE FILE NUMBER 4827

FILED MAY 14 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

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-57
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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 St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 Geitner Home		Length of stay in lb 1 wk		d. STREET ADDRESS (If outside, give location) 5000 S Broadway	

3. NAME OF DECEASED (Type or print) First Middle Last LENA PAULINE ZIDOVINAC			4. DATE OF DEATH Month Day Year May 4, 1958		
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1882	9. AGE (In years birthday) 75	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Wenzken Germany 4	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Julius Rapp	13b. MOTHER'S MAIDEN NAME Maria Randzio	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Geitner Home 5000 S Broadway
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Hypertensive heart disease DUE TO (c) 443x		INTERVAL BETWEEN ONSET AND DEATH 3 hours 1+ years
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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"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 COUNTY STATE
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21. I attended the deceased from 5/4/58 to 5/4/58 and last saw her alive on 5/4/58 Death occurred at 1:25 P m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) N. P. Knudsen MD 0	22b. ADDRESS Washington St. Calif. Mo	22c. DATE SIGNED 5/6/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/7/58	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State) Lemay 23 Mo
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24. FUNERAL DIRECTOR Fendler Und. Co. ADDRESS 7420 Michigan	25. DATE RECD. BY LOCAL REG. MAY 6 '58	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.D.
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(Licensed Embalmer's Statement on Reverse Side)

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 *W. G. Peterson*

Licensed Embalmer No. *3767*
P. O. Address *7420 Mich*

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.