

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023793
STATE FILE NUMBER

318

1003

Registrar's No. 6745

FILED JUL 14 1958

Registration District No. _____ Primary Registration District No. _____

300
1-57
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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 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St John's Hosp		Length of stay in lb 23	d. STREET ADDRESS (If outside, give location) 1317 A Lynch Str Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mildred Middle Stimac Last Stimac			4. DATE OF DEATH Month July Day 4 Year 1958
5. SEX Female	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 Feb 8 1911
9. AGE (In years last birthday) 47		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mt Olive Illinois / U S
13a. FATHER'S NAME Peter Dragovich		13b. MOTHER'S MAIDEN NAME Anna Broats	14. NAME OF HUSBAND OR WIFE Joseph Stimac
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Joseph Stimac 1317 A Lynch Street
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) Adenocarcinoma, rectum 170X DUE TO (c) _____ CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Adenocarcinoma left breast (4 1/2 yrs ago)			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
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 Hour _____ Month, Day, Year _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT <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
21. I attended the deceased from June 1954 to July 4, 1958 and last saw her alive on July 4, 1958 Death occurred at _____ on the _____ date stated above; and to the best of my knowledge, from the cause stated.			
22a. SIGNATURE (Degree or title) Phoebe W. Powers M.D.		22b. ADDRESS 634 W. Grand	22c. DATE SIGNED 7/5/58 (Type)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/8/58	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) St Louis County Mo
24. FUNERAL DIRECTOR Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. JUL 7 58	26. REGISTRAR'S SIGNATURE Carl Smith

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed George J. Luboda Jr......

Licensed Embalmer No. 4899.....

P. O. Address 1926 Allen.....

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.