

Health,  
Welfare  
Public  
Service

300  
1-57

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038227

STATE FILE NUMBER 5879  
Registrar's No.

FILED NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003

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		c. CITY OR TOWN ST. LOUIS	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 4638 LOUGHBOROUGH		d. STREET ADDRESS (If outside, give location) 4638 LOUGHBOROUGH	
Length of stay in lb 2029		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last FRANCES SKERIK			4. DATE OF DEATH Month Day Year OCT 13 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 29 1879	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) ST. LOUIS MO.	12. CITIZEN OF WHAT COUNTRY? U-S-A	

13a. FATHER'S NAME WILLIAM HRUBY		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE FRANK SKERIK SR. (DECD)	
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. NONE		17. INFORMANT CECELIA NIEMEIER 4638 LOUGHBOROUGH	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis with Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Decompensation DUE TO (c) Arteriosclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH slight 1 year 10 Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 422.1			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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 ST. LOUIS	COUNTY	STATE
21. I attended the deceased from May 11 <sup>th</sup> 1956 to Oct. 13 1958 and last saw her alive on Oct. 13-1958 Death occurred at 2:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE H.C. [Signature] (Degree or title) MD		22b. ADDRESS 3606 [Address]		22c. DATE SIGNED 10/15/58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT 16 1958	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM	23d. LOCATION (City, town, or county) ST. LOUIS Co. MO
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois		25. DATE RECD. BY LOCAL REG. OCT 15 58	26. REGISTRAR'S SIGNATURE J. Carl Smith MD

(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 *Leo J. Budde* .....

Licensed Embalmer No. *3289* .....  
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.