

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003656

STATE FILE NUMBER

2 829

FILED FEB 10 1959 Registration District No. Primary Registration District No. Registrar's No.

300
1-57
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33

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2235 Gaine Str		d. STREET ADDRESS (If outside, give location) 2235 Gaine Street	

3. NAME OF DECEASED (Type or print) First Albert Middle (Vodicka) Last Wodicka			4. DATE OF DEATH Month Jan Day 21 Year 1959			
5. SEX Male ♂	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 23 1896		9. AGE (In years last birthday) 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman		10b. KIND OF BUSINESS OR INDUSTRY Brown Shoe Co		11. BIRTHPLACE (City and state or country) St Louis Missouri		

13a. FATHER'S NAME Vaclav Vodicka		13b. MOTHER'S MAIDEN NAME Rose Brynda		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 489-07-5633		17. INFORMANT Address Joseph Vodicka 4333 Gannett Ave	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ventricular arrhythmias			
DUE TO (c) Right ventricular hypertrophy			8 mrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chr. Myocarditis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour None Month None Day None Year None					
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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 Sept. 11-1958 to Jan 21-59 and last saw him alive on Jan. 20-1959 Death occurred at 12:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Joseph J. Smith			22b. ADDRESS 2767 Garois St. No 18 Mo		22c. DATE SIGNED 1-23-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/26/59	23c. NAME OF CEMETERY OR CREMATORY S S Peter & Paul Cem		23d. LOCATION (City, town, or county) (State) St Louis Missouri	
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24. FUNERAL DIRECTOR ADDRESS Moydell Funeral Home 1926 Allen			25. DATE RECD. BY LOCAL REG. JAN 26 59		26. REGISTRAR'S SIGNATURE J. Carl Smith mo	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Svoboda 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.