

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027018

FILED VS JUL 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6607** STATE FILE NUMBER

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		Length of stay in 1b 10 years	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 FIRMIN DES LOGE HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6754 O'DELL Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle (N.M.I.) Last NOVAKOVICH	4. DATE OF DEATH Month JULY Day 12 Year 1959
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5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/26/1902	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY METAL INDUSTRY	11. BIRTHPLACE (City and state or country) CZECHOSLOVAKIA	12. CITIZEN OF WHAT COUNTRY (NAT'L) USA
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13a. FATHER'S NAME JOHN ZURECK	13b. MOTHER'S MAIDEN NAME (UNKNOWN)	14. NAME OF HUSBAND OR WIFE JOSEPH NOVAKOVICH
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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. YES	17. INFORMANT Address JOSEPH NOVAKOVICH, 6754 O'DELL, ST. LOUIS
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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) Melastatic Carcinoma of Ovary		INTERVAL BETWEEN ONSET AND DEATH 1yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	175.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

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 **Aug 1957** to **July 12, 1959** and last saw her ^{him} alive on **July 11, 1959**
Death occurred at **10:00 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Sidney Goldenberg MD	22b. ADDRESS 3720 Washington Blvd	22c. DATE SIGNED 7/14/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/15/1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, County, Missouri
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24. FUNERAL DIRECTOR ADDRESS Hoffmeister Colonial Mortuary 6464 Chippewa Street, St. Louis, Mo	25. DATE RECD. BY LOCAL REG. JUL 14 '59	26. REGISTRAR'S SIGNATURE Head Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed:

Lewis C. Hoffner

Licensed Embalmer No. 3871

P. O. Address 7814 S. Br

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.