

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004136

EILED VS FEB 10 1960

Registration District No. 2 Primary Registration District No. 1004 Registrar's No. 2 1004 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>8 days</u>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>INCARNATE WORD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2722 SULPHUR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>J.</u> Last <u>SUSANKA</u>	4. DATE OF DEATH Month <u>JAN</u> Day <u>25</u> Year <u>1960</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.	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) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mo</u>	11. BIRTHPLACE (City and state or country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOHN DEMSKY</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>FRANK SUSANKA</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name of unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>CARRIE HILDEBRAND</u>	Address <u>2722 SULPHUR</u>
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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) <u>Cerebral Vascular thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, severe generalized</u>		<u>10 years</u>
DUE TO (c) <u>332x</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive cardio-vascular disease</u>		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

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 _____ 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

21. I attended the deceased from Jan 1 1960 to Jan. 25 1960 and last saw her/him alive on Jan 25, 1960
Death occurred at 8:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Rosemary R. Larkin M.D.</u>	22b. ADDRESS <u>2730 Watson Rd</u>	22c. DATE SIGNED <u>1-28-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JAN 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO</u>
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24. FUNERAL DIRECTOR <u>Thomas Kuti</u>	ADDRESS <u>2906 Marvie</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 28 1960</u>	26. REGISTRAR'S SIGNATURE <u>Neal Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 James C. White

Licensed Embalmer No. 4347

P. O. Address 2906 St.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.