

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 6 1960

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9436

-60-036653

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|   |   |   |   |  |   |   |  |
|---|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis,</b>  |   |   | Length of stay in 1b  |  | c. CITY OR TOWN <b>St. Louis,</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Incarinate Word Hosp.</b>   |   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><b>4978 Magnolia</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>AGNES</b> Middle Last <b>TOKRAKS</b>  |   |   |   | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>25th,</b> Year <b>1960</b>   |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-7-1886</b>                                       | 9. AGE (last birthday)<br><b>74</b>  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HR<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                            |  |
| 13a. FATHER'S NAME<br><b>Joseph Henry Quatmann</b>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Kuenen</b>                           |  | 14. NAME OF HUSBAND OR WIFE<br><b>Charles B. Tokraks</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No None</b>  |   | 16. SOCIAL SECURITY NO.<br><b>No</b>  |   | 17. INFORMANT Address<br><b>Joseph H. Tokraks-4978 Magnolia</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b><br>DUE TO (b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO (c) <b>420.1</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>39 hours</b><br><b>JULY 1960</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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 <b>1954</b> to <b>Sept. 1960</b> and last saw her alive on <b>9-25-960</b><br>Death occurred at <b>3:30 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |   |  |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>John M. Parato M.D.</b>  |   |   | 22b. ADDRESS<br><b>4401 Hampton Ave</b>                                   |  | 22c. DATE SIGNED<br><b>9-26-60</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>Sept. 28, 1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Lawn Cemetery</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b>  |   |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Kriegshauser-4228 S.Kingshighway Blvd.</b>   |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>SEP 26 1960</b>                        | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b>   |   |   |  |

DOCUMENT

MEDICAL CERTIFICATION

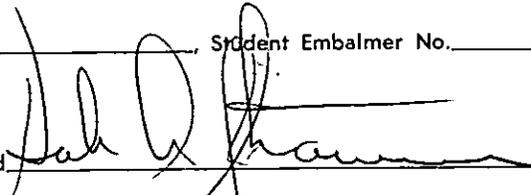
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_  
Student Embalmer No. \_\_\_\_\_

Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

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