RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 19 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9770 STATE FILE NUMBER 60-040240

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN St. Louis
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 3244 Knapp (If outside, give location)
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Anna Middle: Last: Sinak
4. DATE OF DEATH Month: 10 Day: 6 Year: 60
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 10-3-1895
9. AGE (last birthday) 65
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) St. Louis, Missouri U. S. A.
12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME Frank Kalinoski
13b. MOTHER'S MAIDEN NAME Julia
14. NAME OF HUSBAND OR WIFE Joseph Sinak
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Catherine Sinak Address 3244 Knapp

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) & Hepatical Coma
DUE TO (c) 581.0
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. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10/1/60, to 10/6/60 and last saw her/him alive on 10/5/60
Death occurred at 3:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert Potashnick M.D. (Degree or title)
22b. ADDRESS 3720 Washington
22c. DATE SIGNED 10/7/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-10-60
23c. NAME OF CEMETERY OR CREMATORY National
23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR ST. LOUIS FUNERAL HOME ADDRESS 2205 St. Louis Ave.
25. DATE RECD. BY LOCAL REG. OCT 8 1960
REGISTRAR'S SIGNATURE Hoard Smith, M.D.
(Licensed Embalmer's Statement on Reverse Side)

DF 1-9695
3720 Washington
Public Vaughnes

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Robert M. Murr

Licensed Embalmer No. 374

P. O. Address St Louis

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.