

318 Primary Registration District No. 1003 Registrar's No. 3199 STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3199

FILED APR 14 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3422 UTAH ST		d. STREET ADDRESS (If outside, give location) 3422 UTAH ST.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First PHYLISS Middle BERAN Last			4. DATE OF DEATH Month APRIL Day 4 Year 1961		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH MAY 1. 1877	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) AUSTRIA HUNGARY U-S-A.	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME FRANK OCASEK		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE EMIL BERAN SR.		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. NONE	
17. INFORMANT MARTHA BERAN		Address 3422 UTAH ST			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Cardiac Deletation		1 day
DUE TO (b) Arricular fibrillation		12 days
DUE TO (c) Myocarditis widespread		2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis - Senility 433.1		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 **Oct. 10 - 1958** to **April 4 - 1961** and last saw her/him alive on **April 3 - 1961**
Death occurred at **1240 A** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Frank Ocsek Sr. M.D.</i>	(Degree or title)	22b. ADDRESS 2767 Gravois Ave	22c. DATE SIGNED 4-5-61
---	-------------------	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE APR. 6. 1961	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.
---	----------------------------------	--	---

24. GENERAL DIRECTOR Thomas Kutis	ADDRESS 2906 Gravois	25. DATE RECD. BY LOCAL REG. APR 5 1961	26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i>
---	--------------------------------	---	---

AMENDED
 DATE AMENDED
 6
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

PN 2-3000

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James C. Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Drown

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.