

AMENDED

FILED AUG 3 1961 **318**

Primary Registration District No. **1003**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b>			Length of stay in 1b _____		c. CITY OR TOWN <b>St. Louis,</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Incarinate Word Hosp.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5417 Rosa Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNETTE</b> Middle <b>J.</b> Last <b>CEJKA</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>25th.</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-26-1914</b>	9. AGE (last birthday) <b>47</b>	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) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing-Champion</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Anthony J. Cejka</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Bieker</b>		14. NAME OF HUSBAND OR WIFE <b>---</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>John Cejka- #4 Sunset Lane</b> Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) <b>PYELONEPHRITIS and active cortical abscess formation in both kidneys.</b> DUE TO (c) _____ 600.0						INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>8-16-61 to 8-25-61</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Rheumatoid arthritis</b>					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 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.)			
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 <b>Aug. 1954</b> to <b>present</b> and last saw her alive on <b>Aug 24, 1961</b> Death occurred at <b>1:45 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Samuel Schroy M.D.</b>			22b. ADDRESS <b>2730 Watson</b>		22c. DATE SIGNED <b>8-25-61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Aug. 28, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>		
24. FUNERAL DIRECTOR <b>Kriegshauser-4228 S.Kingshighway Blvd.</b> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <b>AUG 26 1961</b>		26. REGISTRAR'S SIGNATURE <b>Loed Smith. M.D.</b>		

INSTEAD OF

18ab See additional information added

BY AFFIDAVIT OF attending physician

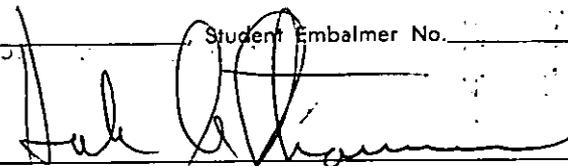
MEDICAL CERTIFICATION

9/21/61

**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  \_\_\_\_\_  
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 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.