

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-1042202-

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10560

FILED NOV 28 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> | | c. CITY OR TOWN <u>St Louis</u> | |
| Length of stay in 1b | | 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>Lutheran Hospital</u> | | d. STREET ADDRESS (If outside, give location) <u>937 Morrison Ave</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Belobrajdic</u> Last | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1961</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/8/1887</u> | 9. AGE (last birthday) <u>73</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days |
| 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>Housework</u> | 11. BIRTHPLACE (City and state or country) <u>Jugoslavia</u> | 12. CITIZEN OF WHAT COUNTRY <u>U S</u> | | |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Blaz</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Charles Belobrajdic 1010 A Russell</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: | | INTERVAL BETWEEN ONSET AND DEATH <u>16 DAYS</u> |
| IMMEDIATE CAUSE (a) | <u>CEREBRAL THROMBOSIS</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) <u>332x</u> | |

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| 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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year _____ |
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| 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 |
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21. I attended the deceased from 10/26/61 to 11/11/61 and last saw her live on 11/11/61
Death occurred at 8 P m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>George A. Deamon MD</u> | 22b. ADDRESS <u>6500 CHIPPEN A</u> | 22c. DATE SIGNED <u>11/13/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>11/15/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St Louis County Mo</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Moydell Funeral Home 1926 Allen</u> | 25. DATE RECD. BY LOCAL REG. <u>NOV 14 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Loan. Smith. M.D.</u> |
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF
ITEM NO.

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 Harley A. Joeller Jr
Licensed Embalmer No. 7950
P. O. Address St Louis

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.