

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007987

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

818

Primary Registration District No.

1003

Registrar's No.

2546

STATE FILE NUMBER

AMENDED

Registration District No.

LED MAR 15 1962

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 checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2104 Allen		d. STREET ADDRESS (If outside, give location) 2104 Allen	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Joseph Dvorak Jr.			4. DATE OF DEATH Month Day Year Mar. 5, 1962			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1904	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (City and state or country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Joseph Dvorak Sr		13b. MOTHER'S MAIDEN NAME Marie Malikova		14. NAME OF HUSBAND OR WIFE Frances		
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.		17. INFORMANT Address Frances Dvorak 2104 Allen		

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Block, Chronic Hypertrophic Myocarditis, decompensated, Cirrhosis of Liver, Amyloidal Degeneration of both Kidneys.</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>decompensated, Cirrhosis of Liver, Amyloidal Degeneration of both Kidneys.</i>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 433.0			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)			
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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Joseph A. Zeman M.D.</i>		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 3-6-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/7/62		23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul	
23d. LOCATION (City, town, or county) St. Louis Mo.		24. FUNERAL DIRECTOR Moynell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. MAR 6 1962	
26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i>					

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 ITEM NO.
 SHOULD READ
 BY REIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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 *Halley F. Jaellie Jr*
Licensed Embalmer No. 4950

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 licensè).

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.