

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033926
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8886

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 6 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

| | | | | | | | | | | | | | |
|--|--|---|---|---|---|---|--|--|--|---|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u> | | Length of stay in 1b | | c. CITY OR TOWN <u>ST Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>12th & RUSSELL</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>2911 VICTOR</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>J.</u> Last <u>MICA</u> | | | | 4. DATE OF DEATH Month <u>SEPT</u> Day <u>1</u> Year <u>1963</u> | | | | | | | | | |
| 5. SEX <u>MALE</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>AUG 12 1904</u> | | 9. AGE (last birthday) <u>59</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEER BOTTLER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BUSCH BREWERY</u> | | 11. BIRTHPLACE (City and state or country) <u>CZECHOSLOVAKIA</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u> | | | | | |
| 13a. FATHER'S NAME <u>JOSEPH MICA</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>JOSEPHINE MANA</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>BARBARA MICA</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or years) <u>YES</u> <u>WWII</u> | | | | 16. SOCIAL SECURITY NO. <u>187</u> | | 17. INFORMANT <u>BARBARA MICA</u> | | Address <u>2911 VICTOR</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 Yrs.</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>4201</u> | | | | | | | | | | | | | |
| 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 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 <u>Jan 1963</u> to _____ and last saw him alive on <u>30 Aug 63</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>S. Dworkin</u> (Degree or title) <u>M.D.</u> | | | | 22b. ADDRESS <u>1657 So Grand</u> | | | | 22c. DATE SIGNED <u>9-2-63</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>SEPT 5 1963</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>SS PETER & PAUL</u> | | 23d. LOCATION (City, town, or county) <u>ST. Louis</u> | | STATE <u>Mo</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Thomas Kutis 2916 Kravis</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>SEP 3 1963</u> | | 26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u> | | | | | | | |

USE BLACK INK OR TYPEWRITER RIBBON

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 J. A. Humphrey

Licensed Embalmer No. 4772

P. O. Address 2906 Broadway

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.

*Dr. John T. Thompson
at New Rochelle*
1711 E. 39th St
Astoria, Ore 97103
Dr. Thompson has this
place 1657 S. Grand
R.R. 6-6200
12-3
Apr 1. 2078