

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042400

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3167

FILED NOV 7 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

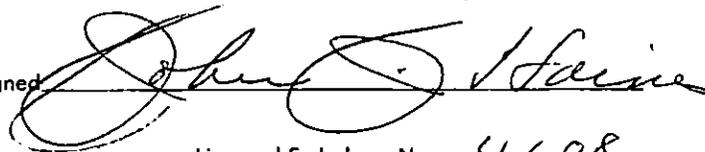
1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch		Length of stay in 1b 156 days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5402 Milentz
3. NAME OF DECEASED (Type or print) First Obren (John) Middle Anton Last (POPVICK) Popovich		4. DATE OF DEATH Month October Day 14 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-15-89
9. AGE (last birthday) 74		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) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Yugoslavia	11. BIRTHPLACE (City and state or country) USA
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Anto Popovich	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Josephine Iukovich	
14. NAME OF HUSBAND OR WIFE -		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 Records of Koch Hosp, Koch, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli			INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pulmonary tuberculosis			
DUE TO (c) Bronchogenic cancer (suspected)			
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 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 5-11-63 to 10-14-63 and last saw him alive on 10-14-63		Death occurred at 1:00 a. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Bernard Friedman		22b. ADDRESS M.D. Robt. Koch Hosp. - Koch, Mo.	
22c. DATE SIGNED 10-14-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 17 63	
23c. NAME OF CEMETERY OR CREMATORY Mount Hope		23d. LOCATION (City, town, or county) (State) St. Louis Cty Mo.	
24. FUNERAL DIRECTOR ADDRESS E.J. Schnur 3125 Lafayette		25. DATE RECD. BY LOCAL REG. 10-15-63	
26. REGISTRAR'S SIGNATURE John G. Murphy M.D.			

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



Licensed Embalmer No. 4108

P. O. Address St Louis Mo

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.