

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **10355**

FILED DEC 9 1943
Registration District No. **91918**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT Marie Janecka
FULL NAME
(b) If veteran, _____ name war No
3. (c) Social Security No. _____

4. Sex Female 5. Color or race Wht. 6. (a) Single, widowed, married, divorced Wed
(b) Name of husband or wife Fred Janecka 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Unknown about 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 64 Unknown _____ hr. _____ min.

9. Birthplace Czechoslovakia
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

FATHER
MOTHER

12. Name John Kozacek
13. Birthplace Czechoslovakia
(City, town, or county) (State or foreign country)
14. Maiden name Unknown Janecka
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Janecka - Son
(b) Address 3855 Fairview Ave.

17. (a) Cremation (b) Date thereof 11/29/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Wm. S. Moydell
(b) Address 1926 Allen Ave.

19. (a) NOV 26 1943 (b) J. T. Bredeck.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis 916
(If outside city or town limits, write "RURAL")
(d) Street No. 3855 Fairview Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26,
year 1943 hour 5:10 minute A. M.
21. I hereby certify that I attended the deceased from November
17, 19 43 to November 26, 19 43;
that I last saw her alive on November 26, 19 43;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____
Of autopsy As above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature John P. Pope (M. D. or other) 11/26/43
Address 1515 Lafayette Ave. Date signed _____

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed A. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen Ave

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 this body is not embalmed, fact should be so stated above.