

FILED FEB 19 1944  
Registration District No. 379

Primary Registration District No. 3063

Registrar's No. 378

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 hrs. 45 min.  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 331 Placid Ave.  
(If rural, give location)  
(e) Citizen of foreign country? Lemay (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Francis Steverak

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Joseph Steverak 6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased 4-16-1881  
(Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. INDUSTRY OR BUSINESS

MOTHER FATHER { 12. Name Joseph Krs  
13. Birthplace Bohemia Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Dora Ruzicka  
15. Birthplace Bohemia Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records  
(b) Address St. Louis County Hospital  
17. (a) Burial (b) Date thereof 2 14 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation near S.S. Peter and Paul  
18. (a) Signature of funeral director Francis Steverak  
(b) Address 2906 Harris ave.  
19. (a) FEB 15 1944 (b) E. G. McKeever, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2-11-44 day \_\_\_\_\_ year \_\_\_\_\_ hour 6:00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 2-11-44, 19\_\_\_\_, to 2-11-44, 19\_\_\_\_; that I last saw her alive on 2-11-44, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 day  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Diabetes mellitus  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Cerebral Hemorrhage

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 0

23. Signature James J. Okey, M.D. (M. D. or other)  
Address 601 Brentwood Blvd, Clayton Date signed 2-12-44

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

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

Signed

*David Van Foran*

Licensed Embalmer No. *49425*

P. O. Address *2906 Jeanis 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.**