

#11170

S. No. 2
DM-2-43
v. 5-17-39DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 11501

Registrar's No. 2938

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
 (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
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____ (Specify whether
 years, months or days)

3. (a) PRINT
FULL NAME

ANNA NOVAK

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 WIDOWED
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased DEC
 (Month) 8-18-67
 (Day) (Year)

8. AGE:

78

Year

Months

Days

If less than one day

hr.

min.

9. Birthplace CZECHOSLOVAKIA
(City, town, or county) (State or foreign country)10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name JOHN TRUBACK
 13. Birthplace CZECHOSLOVAKIA
 (City, town, or county) (State or foreign country)
 14. Maiden name CATHERINE HLEDKO
 15. Birthplace CZECHOSLOVAKIA
 (City, town, or county) (State or foreign country)

16. (a) Informant ANNA VREMICK(b) Address 2821 HICKORY STR17. (a) BURIAL (b) Date thereof 3/29/46
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation OLD SS. PETER & PAUL18. (a) Signature of funeral director Kim B. Maxwell(b) Address 1926 Allen Ave19. (a) MAR 28 1948 (b) Jo F. Braddock
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 209
 (c) City or town ST LOUIS 212
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2650 CHOUTEAU AVE
Memorial (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26th
 year 1946 hour 4:30 minute P M.

21. I hereby certify that I attended the deceased from 12/4/46
 _____, 19____ to 3/26/46, 19____
 that I last saw her alive on 3/26/46, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Retroperitoneal
sarcoma Duration 2 yrs

Due to _____
 Due to _____

Other conditions Gastric ulcer
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy As Above

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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 D. Rederick J. Brinn Jr. (Date signed) 3/27/46
1515 Lafayette Address

(Licensed Embalmer's Statement on Reverse Side)

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 me

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

Signed Benny J. Damian

Licensed Embalmer No. 2272

P. O. Address 1926 Allen

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.