No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3338

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 540

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1309 Russell Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 1309 Russell ave

3. NAME OF DECEASED (Type or Print)
a. (First): ALOISIA
b. (Middle):
c. (Last): TIKWART

4. DATE OF DEATH (Month) (Day) (Year): JAN. 17-1949

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 3-1868

9. AGE (In years last birthday): 80 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Joseph Sip

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Frank Tikwart

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'S SIGNATURE OR NAME: Frank Tikwart — ADDRESS: 1309 Russell

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiovascular renal syndrome — INTERVAL BETWEEN ONSET AND DEATH: several yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis & hypertension — " "
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): no

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/13, 1937, *to* 1/17, 1949, *that I last saw the deceased alive on* 1/15, 1949, *and that death occurred at* 6 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] Ottawa Mo

23b. ADDRESS: 3804 Wilmington Ave.

23c. DATE SIGNED: 1/17/49.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 1-20-1949

24c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul

24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: JAN 19 1949

REGISTRAR'S SIGNATURE: J. B. Lasater

25. FUNERAL DIRECTOR'S SIGNATURE: Mordell Und. — ADDRESS: 1926 Allen Ave.

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No. ..... working under my personal supervision.

Signed Benj. C. Duncan

Signed ..... Student Embalmer

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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