

FILED MAY 23 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 17877

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6576		Registrar's No. 1072	
1. PLACE OF DEATH a. COUNTY St. Louis County				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charlesville		d. STREET ADDRESS (If rural, give location) 7928 Joel Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital							
3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) _____ c. (Last) KUBRICKY			4. DATE OF DEATH (Month) (Day) (Year) May 12 1949				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec 13 1885		9. AGE (In years) Years: 63 Months: _____ Days: _____	IF UNDER 1 YEAR Months: _____ Days: _____	IF UNDER 24 HRS. Hours: _____ Mins: _____
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 6		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME Thomas Baca		13b. MOTHER'S MAIDEN NAME Elizabeth Urban		14. NAME OF HUSBAND OR WIFE George Kubricky			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME George Kubricky 7928 Joel Street ADDRESS _____			
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis			INTERVAL BETWEEN ONSET AND DEATH 24 days
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis 332X 20 yrs			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 4-19-49 , to 5-12-49 , that I last saw the deceased alive on 5-12-49 , and that death occurred at 3:30 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE John W. Jones MD (Degree or title)				23b. ADDRESS 601 S Brentwood Clayton		23c. DATE SIGNED 5-12	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/16/49	24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo		
DATE REC'D BY LOCAL REG. 5-13-49		REGISTRAR'S SIGNATURE Thurmond W. Lamminger MD		25. FUNERAL DIRECTOR'S SIGNATURE Wm. Moyall ADDRESS 1926 Allen Av			

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

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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.

Student
Student Embalmer

Signed Benny J. Duncan

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.