

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25062

FILED JUL 30 1949

State File No. 6395

318

1003

6395

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>4031 Tholozan Av.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHANNA</u> b. (Middle) <u>HONCARIC</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 21 - 49</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIAGE STATUS <u>SINGLE</u> WIDOWED, NEVER MARRIED, DIVORCED		8. DATE OF BIRTH <u>MARCH 21 - 1909</u>	
9. AGE (In years last birthday) <u>40 YRS</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIL</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS MO.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>MICHAEL HONCARIC</u>		13b. MOTHER'S MAIDEN NAME <u>BARBARA ANTIC</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Barbara Loncaric 4031 Tholozan</u>			
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) <u>Capillary Carcinoma of ovary & generalized metastases</u> ANTECEDENT CAUSES Morbid 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. _____				INTERVAL BETWEEN ONSET AND DEATH <u>206 days</u>	
19a. DATE OF OPERATION <u>2-5-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Generalized metastases</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) <u>St. Louis City Mo.</u>			
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 <u>Hg</u>			
22. I hereby certify that I attended the deceased from <u>17 January 1949</u> , to <u>20 July 1949</u> , that I last saw the deceased alive on <u>20 July 1949</u> , and that death occurred at <u>6:22 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>William Sillepiz M.D.</u>				23b. ADDRESS <u>4952 Mamland</u>		23c. DATE SIGNED <u>22 July 49</u>	
24a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>BURIAL</u>		24b. DATE <u>JULY 25 - 49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUL 25 1949</u>		REGISTRAR'S SIGNATURE <u>B. Casater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E. J. Schurz 3125 Lafayette</u>			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Joseph Blalock

Licensed Embalmer No. 4014

P. O. Address 3125

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.