

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28582
State File No. _____
Registrar's No. 7267

BIRTH NO. _____		REG. DIST. NO. <u>318</u>	PRIMARY REG. DIST. NO. <u>1003</u>
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>12 (21)</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) <u>23 1844 Russell</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Sanitarium</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 18, 1949</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPHINE</u> b. (Middle) <u>STIKA</u> c. (Last) _____		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	
8. DATE OF BIRTH <u>2-27-1882</u>		9. AGE (In years last birthday) <u>67</u> If under 1 year: Months <u>5</u> Days <u>21</u> If under 12 hrs: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wkr</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Frank Stika</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Znijsak</u>	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Frank Stika Jr.</u> ADDRESS <u>2125 So. Jefferson</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>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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>930</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>4200</u>		22. I hereby certify that I attended the deceased from <u>Jan. 20</u> 19 <u>47</u> , to <u>Aug. 18</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Aug. 18</u> , 19 <u>49</u> , and that death occurred at <u>1:40 P.m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>Dr. Henry K. Burch, M.D.</u>		23b. ADDRESS <u>5400 Arsenal St.</u>	
23c. DATE SIGNED <u>8/18/49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>8-22-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Old St. Peter & Paul</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>		DATE REC'D BY LOCAL REG. <u>AUG 21 1949</u>	
REGISTRAR'S SIGNATURE <u>J. H. L. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Maydell Funeral Home</u> ADDRESS <u>1926 Allen</u>	

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

over

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 _____

Dale C. Krausman

Licensed Embalmer No. 4533

P. O. Address 1956 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.