

FILED NOV 5 1949

STANDARD CERTIFICATE OF DEATH

State File No. **35444**
9235

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St, Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Firmen-Desloge Hospital		d. STREET ADDRESS (If rural, give location) 4040 Minnisota	
3. NAME OF DECEASED (Type or Print) a. (First) EMILY b. (Middle) J. c. (Last) NOVAK		4. DATE OF DEATH (Month) (Day) (Year) Oct 26 1949 11/30	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 4 1897
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____	11. BIRTHPLACE (State or foreign country) St. Louis Mo
10b. KIND OF BUSINESS OR INDUSTRY Athome		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Gottlieb Link		13b. MOTHER'S MAIDEN NAME Josephine Drenkler	
13c. NAME OF HUSBAND OR WIFE John Arthur Novak		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME J.A. Novak		ADDRESS 4040 Minnisota	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial asthma 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. no	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) no	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21b. (CITY, TOWN, OR TOWNSHIP), (COUNTY), (STATE) 112	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR? 341X		22. I hereby certify that I attended the deceased from Aug. 5, 1947 , to Oct. 26, 1949 , that I last saw the deceased alive on Oct. 25, 1949 , and that death occurred at 11/30AM , from the causes and on the date stated above.	
23a. SIGNATURE Henry P. Oppenheimer M.D. (Degree or title)		23b. ADDRESS 508 N. Grand Blvd., St. Louis 37 Mo	
23c. DATE SIGNED Oct. 28, 1949		24a. BURIAL OR CREMATION (Specify) Burial	
24b. DATE 10-29-1949		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Prk	
24d. LOCATION (City, town, or county) (State) St. Louis MO		25. FUNERAL DIRECTOR'S SIGNATURE WINGBERMUEHLE ADDRESS 3819 S, GRAND Blvd	
DATE REC'D BY LOCAL REG. OCT 27 1949		REGISTRAR'S SIGNATURE J. B. Basater	

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Van M. Susemore

Signed _____
Student Embalmer

Licensed Embalmer No. 4343

P. O. Address Adams St

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.