

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43110
State File No. 10797
Registrar's No.

BIRTH NO. 104029 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		d. STREET ADDRESS (If rural, give location) 2648 ^A CHOUTEAU AVE.	
c. LENGTH OF STAY (in this place)		3. NAME OF DECEASED a. (First) BLASE		b. (Middle) ZORICH	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1949			
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH FEB 3-1976	9. AGE (In years last birthday) 73 YR	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) AUGUSTA, GA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME ANTON Zorich		13b. MOTHER'S MAIDEN NAME FRANCES UNK.		14. NAME OF HUSBAND OR WIFE Mary Zorich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Anthony Zorich 2648 ^A Chouteau Ave.	
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) Adenocarcinoma of Recto sigmoid ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) with generalized metastases 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
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) Hickory MO	
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? 107X	
22. I hereby certify that I attended the deceased from 12/10/49, 19, to 12/14/49, that I last saw the deceased alive on 12/14/49, and that death occurred at 7:35 AM, from the causes and on the date stated above.					
23a. SIGNATURE Harlow Hendrick M.D.		(Degree of title)		23b. ADDRESS 1515 Lafayette Ave., 12/14/49	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE DEC 16-49	
24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		24d. LOCATION (City, town, or county) (State) St. Louis MO			
DATE REC'D BY LOCAL REG. DEC 15 1949		REGISTRAR'S SIGNATURE E. J. Schmur		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schmur 3125 Lafayette	

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.....

Joe B. Pollmer

Licensed Embalmer No. *312574*

P. O. Address *4014*

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.