

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6358
Registrar's No. 1281

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		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 OR TOWN St Louis)		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL and give township) St Louis		d. STREET ADDRESS 1528 Locust	
d. FULL NAME OF HOSPITAL OR INSTITUTION Downtown YMCA-1528 Locust		d. STREET ADDRESS (If rural, give section)	
3. NAME OF DECEASED (Type or Print) a. (First) Ralph		b. (Middle)	
c. (Last) Janek		4. DATE OF DEATH (Month) (Day) (Year) Feb 8, 1950	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Oct 20, 1910
9. AGE (In years last birthday) 39		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Michael Janek	
13b. MOTHER'S MAIDEN NAME Katie Melcie		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war-pr dates of service) WW-2		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Wm Janek		ADDRESS 4535 Shaw	
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) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary thrombosis 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 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) St Louis Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:09 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Wm Janek		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 2/9/50			
24a. BURYAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/11/50	
24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery		24d. LOCATION (City, town, or county) (State) St Louis County, Mo.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE J. B. L...	
FEB 9 1950		25. FUNERAL DIRECTOR'S SIGNATURE Ziegenhein & Sons ADDRESS 7027 Gravois	

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

261

275

[Handwritten mark]

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 *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7027 Gravois*

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.