

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6562

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1076

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) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent		d. STREET ADDRESS 807 1/2 Market					
3. NAME OF DECEASED (Type or Print) John Novack		b. (Middle)		4. DATE OF DEATH 2 6 50			
5. SEX Male		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never		8. DATE OF BIRTH 4-11-180			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years, months, days, hours, min.) 70 11 17 0			
11. BIRTHPLACE (State or foreign country) Czech		12. CITIZEN OF WHAT COUNTRY? Czech					
13a. FATHER'S NAME None		13b. MOTHER'S MAIDEN NAME None		14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. DECEASED'S SIGNATURE OR NAME John Novack			
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, asphyxia, 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) 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) 5870			
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 _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Joseph M. Suran, Deputy Coroner		23b. ADDRESS 11300 Clark		23c. DATE SIGNED 2/17/50			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE FEB 21 1950		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board			
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.					
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 21 1950 J. B. Parater		ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.					

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~~ by Student
at College of Mortuary Science Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed Ralph W. Henson

Licensed Embalmer No. 3791

P. O. Address St. Louis, Mo.

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.