

FILED SEP 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 28324
7503
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No.	
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 town) _____		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) _____		OR TOWN _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) _____		b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) 9 1 50	
5. SEX _____		6. COLOR OR RACE _____		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		8. DATE OF BIRTH _____	
Female		White		Married		Nov 24 1906	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____		9. AGE (In years last birthday) _____	
HWK						43	
11. BIRTHPLACE (State or foreign country) _____				12. CITIZEN OF WHAT COUNTRY? _____		U.S.	
13a. FATHER'S NAME _____				13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE _____	
Joseph Kvaternik				Anna Malcic		Frank Jakovich	
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 _____	
NO						Frank Jakovich 4026 Tholozan	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) _____		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH _____	
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) _____				6-27-50	
		ANTECEDENT CAUSES				10-5-49	
		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.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10-5-49		Ca of Breast					
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) _____			
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? _____		170X	
22. I hereby certify that I attended the deceased from 6-27, 1950, to 9-1, 1950, that I last saw the deceased alive on 8-31, 1950, and that death occurred at 9 a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) _____				23b. ADDRESS _____		23c. DATE SIGNED _____	
John E. Kennedy M.D. M.M.				2227a So Broadway		9-2-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE _____		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) _____ (State) _____	
Burial		9-5-50		Resurrection Cem		St. Louis Mo	
DATE REC'D BY LOCAL REG. _____		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR'S SIGNATURE _____		ADDRESS _____	
SEP 3 1950		J. B. Pasatera		Moylell Funeral Home 1926 Allen.			

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

