

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1951

State File No. 2701
532

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri 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 2113 Menard Street		d. STREET ADDRESS (If rural, give location) 2113 Menard Street	

3. NAME OF DECEASED (Type or Print) Katherine	a. (First)	b. (Middle)	c. (Last) Kucera	4. DATE OF DEATH (Month) (Day) (Year) Jan 15 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov 6 1863	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Czechoslovakia	12. CITIZEN OF WHAT COUNTRY? U S
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13a. FATHER'S NAME William Vaclavik	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE John (Deceased)
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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 Mae Boubek	ADDRESS 2113a Menard Street
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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		INTERVAL BETWEEN ONSET AND DEATH 6 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Chronic myocarditis</i>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 422, 2
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22. I hereby certify that I attended the deceased from 10-29, 1945, to Jan 15, 1951, that I last saw the deceased alive on 1-15, 1951, and that death occurred at 12:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE <i>John A. Smith</i>	(Degree or title)	23b. ADDRESS 2840 California	23c. DATE SIGNED 1-18-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/20/51	24c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Mo.
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DATE REC'D BY LOCAL REG. JAN 18 1951	REGISTRAR'S SIGNATURE <i>J. Stasch</i>	25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home	ADDRESS 1926 Allen Av
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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 me

working under my personal supervision.

Student Embalmer No.....

Signed Dale A. Strawn

Signed.....
Student Embalmer

Licensed Embalmer No. 4533

P. O. Address 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.