

FILED MAR 2 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6281**  
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1578**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Anthony Hosp</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b> <b>2159</b>	
		d. STREET ADDRESS (If rural, give location) <b>4564 Ray</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Theresa</b> b. (Middle) c. (Last) <b>Kacer</b>		4. DATE OF DEATH (Month) <b>2</b> (Day) <b>14</b> (Year) <b>51</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>9-17-1871</b>
9. AGE (In years last birthday) <b>79</b>		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) <b>Hwk</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b> <b>6</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Joseph Svec</b>	
13b. MOTHER'S MAIDEN NAME <b>Marie Rataje</b>		14. NAME OF HUSBAND OR WIFE <b>Albert Kacer Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <b>Anna Duchek</b>		ADDRESS <b>3525 Oregon</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of stomach with</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <b>generalized metastasis</b> DUE TO (c) <b>Senility</b> 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 <b>Impenetrable carcinoma of stomach with general metastasis</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>gm</b>		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) <b>gm</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>157X</b>			
22. I hereby certify that I attended the deceased from <b>Jan 20, 1951</b> , to <b>Feb 14, 1951</b> , that I last saw the deceased alive on <b>Feb 14, 1951</b> , and that death occurred at <b>10:30 p.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>S. H. Mayo, MD</b>		23b. ADDRESS <b>3606 GRAVIER AVE</b>	
23c. DATE SIGNED <b>2-16-51</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>2-17-51</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem</b>		24d. LOCATION (City, town, or county) (State) <b>Edwardsville Ill</b>	
DATE REC'D BY LOCAL REG. <b>FEB 16 1951</b>		REGISTRAR'S SIGNATURE <b>J B Suster</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Moynell Funeral Home</b>		ADDRESS <b>1926 Allen</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Paul A. Steumann

Licensed Embalmer No. 4533

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.