

FILED MAR 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6282

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1678**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> 2079	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>5804 Amelia</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5804 Amelia</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Richard</u> b. (Middle) <u>Lee</u> c. (Last) <u>Kajzo</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 17 51</u>	
5. SEX <u>M.O.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED; NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>5-14-48</u>
9. AGE (In years last birthday) <u>2</u> IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u> IF UNDER 12 HRS. Hours <u>3</u> Min.		11. BIRTH PLACE (State or foreign country) <u>St. Louis, Mo.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <u>Paul Kajzo</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Ernst</u>	14. NAME OF HUSBAND OR WIFE
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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 <u>Paul Kajzo - 5804 Amelia</u>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malignant Hepatoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>
	ANTECEDENT CAUSES Morbidity 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 <u>enlarged liver</u>	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)
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? <u>1557 1537</u>

22. I hereby certify that I attended the deceased from 12-19 1950 to 2-17 1951, that I last saw the deceased alive on 2-17 1951, and that death occurred at 12:09 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Gerard M. D.</u>	23b. ADDRESS <u>817 Olive St. St. Louis</u>	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-20-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>
24d. LOCATION (City, town, or county) (State) <u>St. Louis MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Labater</u>
DATE REC'D BY LOCAL REG. <u>FEB 20</u>		ADDRESS <u>St. Louis Funeral Home, 2205 - 44th St. St. Louis</u>

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 Elton H. Remelius

Licensed Embalmer No. 4293

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.