

FILED MAR 7 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6544
Registrar's No. 1751

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) West Frankfort 8120	
c. LENGTH OF STAY (in this place) 1 mo 20 days		d. STREET ADDRESS (If rural, give location) 1203 85th Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Helen	b. (Middle) Frances	c. (Last) Pudil	4. DATE OF DEATH (Month) (Day) (Year) 2 20 51
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-9-1913	9. AGE (In years last birthday) 38	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR 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) Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Yalko	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE George
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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 George L. Pudil	ADDRESS West Frankfort Ill
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive cardiovascular disease with uremia		3 years
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia, terminal		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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? W H 21
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22. I hereby certify that I attended the deceased from **12/31 1950**, to **2/20 1951**, that I last saw the deceased alive on **2/20 1951**, and that death occurred at **8:25a** m., from the causes and on the date stated above.

23a. SIGNATURE F R Bradley (Degree or title) M.D.	23b. ADDRESS Barnes Hospital	23c. DATE SIGNED 2/20/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-20-51	24c. NAME OF CEMETERY OR CREMATORY West Frankfort	24d. LOCATION (City, town, or county) (State) Ill
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DATE REC'D BY LOCAL REG. FEB 22 1951	REGISTRAR'S SIGNATURE J B L...	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4-02-51 10

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed

Ronald J. Yahrke

Licensed Embalmer No. *2917*

P. O. Address *St Louis 10-M*

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.