

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21293

FILED JUN 29 1951

318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 5600

BIRTH NO. <u>39992-51</u>		REG. DIST. NO.		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>5600</u>					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Ill.</u> b. COUNTY							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS 10, MISSOURI</u>		c. LENGTH OF STAY (In this place) township) <u>25 mins.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>E. St. Louis 8120</u>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS MATERNITY HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>1515 N. 33rd St</u>							
3. NAME OF DECEASED (Type or Print) <u>INFANT MALE KOMESHAK</u>			a. (First)		b. (Middle)		c. (Last)				
4. DATE OF DEATH (Month) (Day) (Year) <u>6-13-51</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NO</u>		8. DATE OF BIRTH <u>6-13-51</u>			
9. AGE (In years last birthday)		IF UNDER 1 YEAR		MONTHS		DAYS		IF UNDER 24 HRS. Hours Min. <u>25</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>				11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS 10, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>STEVE (MAY) KOMESHAK</u>			13b. MOTHER'S MAIDEN NAME <u>CATHERINE GENEVA CAPPS</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>STEVE & CATHERINE GENEVA KOMESHAK</u>				ADDRESS <u>1515 N. 53rd St. E. ST. LOUIS, ILL.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Birth asphyxia</u>						INTERVAL BETWEEN ONSET AND DEATH			
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prolapsed cord</u>									
		DUE TO (c) <u>Transverse presentation</u>									
		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 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>76.1. 0</u>							
22. I hereby certify that I attended the deceased from <u>6-13-51</u> , 19 <u>51</u> , to _____, 19____, that I last saw the deceased alive on <u>6-13-</u> , 19 <u>51</u> , and that death occurred at <u>12:50A m.</u> , from the causes and on the date stated above.											
23a. SIGNATURE <u>Paul F. Max M.D.</u>				(Degree or title)		23b. ADDRESS <u>3720 Washington Blvd.</u>		23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>6 JUN 21 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anderson Home</u>		24d. LOCATION (City, town, or county) (State)					
DATE REC'D BY LOCAL REG. <u>JUN 21 1951</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland Bernier - 4104 W. an. charter</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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.