

FILED JUL 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24872

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6332	
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. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 11		2319	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Brothers Hospital				d. STREET ADDRESS (If rural, give location) 7331 Virginia			
3. NAME OF DECEASED (Type or Print) a. (First) Robert		b. (Middle) W.		c. (Last) Kocian		4. DATE OF DEATH (Month) (Day) (Year) July 14, 1951	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Aug. 1, 1881	
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Kocian		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Mary Agnes Kocian	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rose Schmitt, 7023 Minnesota			
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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Oedema due to arterial sclerosis ANTECEDENT CAUSES Chronic Nephro Sclerosis DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH 5 1/2 weeks	
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) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H46 X					
22. I hereby certify that I attended the deceased from 6-6 , 19 51 , to 7-14 , 19 51 , that I last saw the deceased alive on 7-14 , 19 51 , and that death occurred at 4 P. m., from the causes and on the date stated above.							
23a. SIGNATURE A. L. Keitel, M.D.				23b. ADDRESS 3606 Gravois		23c. DATE SIGNED 7-16-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 16, 1951		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		24d. LOCATION (City, town, or county) (State) Lemay, 23, Mo.	
DATE REC'D BY LOCAL REG. JUL 16 1951		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fendler Und. Co., 7420 Michigan Ave.			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

W. E. Morris

Signed.....

Student Embalmer

Licensed Embalmer No. *3360*

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.