

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43336

FILED JAN 10 1952

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State File No. _____

11225

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		b. COUNTY 2121	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3925 Mc Donald Av		STREET ADDRESS (If rural, give location) 3925 Mc Donald Av	

3. NAME OF DECEASED (Type or Print) a. (First) Henry	b. (Middle)	c. (Last) Sladzinik	4. DATE OF DEATH (Month) (Day) (Year) Dec 17 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 23 1872	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Czechoslovakia 6	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Caroline
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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 Caroline Sladzinik	ADDRESS 3925 McDonald
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <i>Carcinoma of Intestine</i>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
	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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 153X
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22. I hereby certify that I attended the deceased from 9-10, 1951, to 12-17, 1951, that I last saw the deceased alive on 12-16, 1951, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>1813 19th Reed M.D.</i>	(Degree or title)	23b. ADDRESS 1446 So. Lindwood	23c. DATE SIGNED 12-18-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/20/51	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Missouri
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DATE RECEIVED BY LOCAL REGISTRY DEC 19 1951	REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Moydell</i>	ADDRESS Moydell Funeral Home 1926 Allen Av
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(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

working under my personal supervision.

Signed George J. Subada Jr.
Student Embalmer

Student Embalmer No. 421

Signed Hale A. Hannan

Licensed Embalmer No. 4533

P. O. Address 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.