

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

43455

State File No. _____

FILED JAN 16 1952

11743

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY 220	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis M	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2214a Mullamphy Str		d. STREET ADDRESS (If rural, give location) 2214a Mullamphy Str	

3. NAME OF DECEASED (Type or Print)	a. (First) Martha	b. (Middle) Julia	c. (Last) Yerke	4. DATE OF DEATH (Month) (Day) (Year) 12-30-51
-------------------------------------	-----------------------------	-----------------------------	---------------------------	----------------------------------------------------------

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH Aug 5- 83	9. AGE (In years last birthday) 68 IF UNDER 1 YEAR Months Days Hours Min.
--------------------	------------------------------	--------------------------------------------------------------------	--------------------------------------	----------------------------------------------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St Louis Mo	12. CITIZEN OF WHAT COUNTRY?
------------------------------------------------------------------------------------------------------------------	-----------------------------------	-----------------------------------------------------------------	------------------------------

13a. FATHER'S NAME Joseph Kowalkoska	13b. MOTHER'S MAIDEN NAME Julia Annis	14. NAME OF HUSBAND OR WIFE Frank Yerke
------------------------------------------------	-------------------------------------------------	---------------------------------------------------

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 Frank Yerke	ADDRESS 2214a Mullamphy
-----------------------------------------------------------------------------------------------------------	-------------------------	---------------------------------------------------------	-----------------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Approximatly 1 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) metastatic carcinoma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Abdominal Carcinoma 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 1991	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
------------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from **9 July, 1951**, to **30 Dec, 1951**, that I last saw the deceased alive on **29 Dec, 1951**, and that death occurred at **8 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE John F. McClain M.D.	(Degree or title)	23b. ADDRESS St. John's Hospital	23c. DATE SIGNED 31 Dec 51
-----------------------------------------------	-------------------	--------------------------------------------	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) B	24b. DATE 1/3/52	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Mo
-------------------------------------------------------	----------------------------	---------------------------------------------------------------	---------------------------------------------------------------------

DATE RECD BY LOCAL REG. JAN 2 1952	REGISTRAR'S SIGNATURE Paul Smith	25. FUNERAL DIRECTOR'S SIGNATURE Central Und Co	ADDRESS 1841 Cass 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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

John D. Hennel
Licensed Embalmer No. 4194
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.