

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6808

FILED FEB 27 1952

State File No. _____
Registrar's No. **1084**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
c. LENGTH OF STAY (In this place)		2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3915 California Av		d. STREET ADDRESS (If rural, give location) 24 3915 California Av	

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Eva c. (Last) Svoboda		4. DATE OF DEATH (Month) (Day) (Year) Feb 3 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/24/90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 61 IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.
11. BIRTHPLACE (State or foreign country) St Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U S	

13a. FATHER'S NAME Frank Ptacek	13b. MOTHER'S MAIDEN NAME Mary Klima	14. NAME OF HUSBAND OR WIFE John W Svoboda
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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 John W Svoboda	ADDRESS 3915 California Av
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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 30 min 1 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ac. Cardiac Debat.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Carcinoma of large intestine & metastases to liver & rech		
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 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4222H
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22. I hereby certify that I attended the deceased from **Feb 3**, 19**50**, to **2-3**, 19**52**, that I last saw the deceased alive on **2-3**, 19**52**, and that death occurred at **11 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Green S. Czekis M.D.	23b. ADDRESS 75 - Levee, St Louis	23c. DATE SIGNED 2-4-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/6/52	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. FEB 4 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Moydell	ADDRESS Funeral Home 1926 Allen Av
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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.....
Student Embalmer

Signed Paul A. Schumann
Student Embalmer No.

Licensed Embalmer No. 4533

P. O. Address St. 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.