

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40415**  
Registrar's No. **10959**

FILED DEC 12 1952

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

|  |  |  |  |   |           |  |  |  |
|--|--|--|--|---|-----------|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>318</b>  |  | PRIMARY REG. DIST. NO. <b>1003</b>  |           | Registrar's No. <b>10959</b>                                       |  |  |
| 1. PLACE OF DEATH<br>a. COUNTRY _____  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY _____ |           |  |  |  |
| b. CITY OR TOWN <b>ST. LOUIS MO</b>  |  | c. LENGTH OF STAY (In this place) _____  |  | c. CITY OR TOWN <b>ST. LOUIS</b> <b>2179</b>  |           |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. ANTHONY'S HOSPITAL 17</b>   |  |  |  | d. STREET ADDRESS (If rural, give location) <b>2704 - ARKANSAS</b>  |           |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>BARBARA - KUDA</b>   |  |  | a. (First)                                       | b. (Middle)   | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>NOV. 27 1952</b>       |  |  |
| 5. SEX <b>FCMAK</b>  |  | 6. COLOR OR RACE <b>WHITE</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>   |           | 8. DATE OF BIRTH <b>OCT. 3 1891</b>                                |  |  |
| 9. AGE (In years last birthday) <b>61</b>  |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 2 HRS. Hours Mins.   |           |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b> |   |           | 11. BIRTHPLACE (City and State or Foreign Country) <b>MISSOURI</b> |  |  |
| 12. CITIZEN OF WHAT COUNTRY? _____   |  | 13a. FATHER'S NAME <b>JOSEPH SUCHY</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>  |           | 14. NAME OF HUSBAND OR WIFE <b>JOSEPH KUDA</b>                     |  |  |
| 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. <b>NONE</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>JOSEPH KUDA 2704 - ARKANSAS</b>  |           |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Embolism</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Abscess, Left groin, drained</b><br>DUE TO (c) <b>Diabetes Mellitus</b><br><br>II. OTHER SIGNIFICANT CONDITIONS -<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |           |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>at once</b><br><br><br><br><br><br><br><br><br><br><b>?</b> |  |
| 19a. DATE OF OPERATION <b>11/17/52</b>   |  | 19b. MAJOR FINDINGS OF OPERATION <b>Opened and drained abscess, Left groin</b>   |  |   |           |  | 20. AUTOPSY?<br>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) _____  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR? <b>260X</b>  |           |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>11/10 1952</b> , to <b>11/27</b> , 19 <b>52</b> ; that I last saw the deceased alive on <b>11/27</b> , 19 <b>52</b> , and that death occurred at <b>11:30A</b> m., from the causes and on the date stated above. |  |  |  |   |           |  |  |  |
| 23a. SIGNATURE <b>A. M. Oster</b> (Degree or title) <b>M.D.</b>  |  |  |  | 23b. ADDRESS <b>4145 a S. Grand Blvd.</b>   |           | 23c. DATE SIGNED <b>11/28/52</b>                                   |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>   |  | 24b. DATE <b>DEC. 1 1952</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>   |           | 24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>  |  |  |
| DATE REC'D BY LOCAL REG. <b>NOV 28 1952</b>  |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith MO</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thomas Ruteis 2906 Grand</b>  |           |  |  |  |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

June 20, 1907  
4145 & J. Street.  
St. Louis

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 Leo J. Buddle

Licensed Embalmer No. 3989

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.