

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12225**
Registrar's No. **3006**

FILED APR 4 1953

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 town) 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 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1859 Menard Street		d. STREET ADDRESS (If rural, give location) 23 1859 Menard Street			
3. NAME OF DECEASED (Type or Print) a. (First) Susan b. (Middle) c. (Last) Ridzak			4. DATE OF DEATH (Month) (Day) (Year) 3 18 53		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8-14-1867	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U S
13a. FATHER'S NAME Joseph Bosan		13b. MOTHER'S MAIDEN NAME Eva Koruncak		14. NAME OF HUSBAND OR WIFE George (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lucia Ostrak 1859 Menard Street	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocardial insufficiency ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Seridity DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Chronic Liver sclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 mos 6 yrs
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4222	
22. I hereby certify that I attended the deceased from 2-1- , 19 53 , to 3-19- , 19 53 , that I last saw the deceased alive on 3-17- , 19 53 , and that death occurred at 8:30 m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) L. F. Murray M.D.			23b. ADDRESS 605-A-Russell		23c. DATE SIGNED 3-19-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3/20/53	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo.
DATE REC'D BY LOCAL REG. MAR 19 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen Av	

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 *Dale A. Stammann*

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.