

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

22772

State File No.

FILED JUN 20 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5462

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>21st</u>	
b. CITY OR TOWN <u>ST. LOUIS Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>14 5421 DELOR</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ALEXIAN BROS Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>MIRO</u> b. (Middle) <u>-</u> c. (Last) <u>CIZEK</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 31 1953</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 18 1900</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKKEEPER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOSEK REALTY CO</u>	11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>WILLIAM CIZEK</u>	13b. MOTHER'S MAIDEN NAME <u>BARBARA STANKOOSKY</u>	14. NAME OF HUSBAND OR WIFE <u>MARIE CIZEK</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>MARIE CIZEK</u> ADDRESS <u>5421 DELOR</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchogenic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>of Right Lung</u>		
	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 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <u>162X</u>
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22. I hereby certify that I attended the deceased from Jan 10, 1953, to May 31, 1953, that I last saw the deceased alive on May 31, 1953, and that death occurred at 12:41 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>J. P. Smith M.D.</u> (Degree or title)	23b. ADDRESS <u>3406 Sharnis</u>	23c. DATE SIGNED <u>6/1/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>JUNE 3 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
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DATE REC'D BY LOCAL REG. <u>JUN 1 1953</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kuteri</u> ADDRESS <u>2906 Seaside</u>
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.