

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26697

FILED JUL 31 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6464**

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. LENGTH OF STAY (in this place) 3 Days	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		* STREET ADDRESS (If rural, give location) 5412 Finkman Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Mihelcic c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) June 26, 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH September 18, 1878	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 9 Days 8 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beer Bottler		10b. KIND OF BUSINESS OR INDUSTRY Busch Brewery		11. BIRTHPLACE (City and State or Foreign Country) Austria	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME John Mihelcic		13b. MOTHER'S MAIDEN NAME Not known		14. NAME OF HUSBAND OR WIFE Agnes Mihelcic	
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. 489-01-7353		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Agnes Mihelcic 5412 Finkman Ave.	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage (Rt hemiplegia) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 6/16/53	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		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) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 6-26-53 331X	
22. I hereby certify that I attended the deceased from 6-26-53 to 6-26-53 , 19 53 , that I last saw the deceased alive on 6-26-53 , and that death occurred at 9:45 P m., from the causes and on the date stated above.					

23a. SIGNATURE D. C. [Signature] (Degree or title)		23b. ADDRESS 4523 S Kings Highway		23c. DATE SIGNED 6/29/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/29/53		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery St. Louis Mo.	

DATE REC'D BY LOCAL REG. JUN 29 1953		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons 2630 Gravois Ave.	
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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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ronald Yabuke*.....

Licensed Embalmer No. 3917.....

P. O. Address 4106 Manchester.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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