

STANDARD CERTIFICATE OF DEATH

State File No. 40375

FILED NOV 24 1953

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10622

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If invitation: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If rural, give location) 23 2055 Russell Blvd	
3. NAME OF DECEASED a. (First) Dr Kristine		b. (Middle) D	c. (Last) Dolezal
4. DATE OF DEATH (Month) (Day) (Year) Nov 7 1953	5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 27 1895	9. AGE (In years last birthday) 58	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Czechoslovakia 6		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Ochman		13b. MOTHER'S MAIDEN NAME Marie Sharupa	14. NAME OF HUSBAND OR WIFE Jerome R.
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 ADDRESS Jerome R Dolezal Jr 2055 Russell Av	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Primary Ca of Ovary or hyperplasia</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Abdominal Carcinoma</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 Aug 3	19b. MAJOR FINDINGS OF OPERATION Pituitary gland from brain (see above)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) no		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) no	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? no 175X		

22. I hereby certify that I attended the deceased from July 21, 1953, to Nov 7, 1953 that I last saw the deceased alive on Nov 7, 1953, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE Henry H. Hegen ⁰ M.D.		(Degree or title)	23b. ADDRESS 508 N. Grand	23c. DATE SIGNED 11/9/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11/10/53	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) St Louis Mo.	

DATE REC'D BY LOCAL REG. NOV 9 1953	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home	ADDRESS 1926 Allen Av
--	---	--	--------------------------

(Licensed Embalmer's Statement on Reverse Side)

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 Reinhold A. Lohmann

Licensed Embalmer No. 3395

P. O. Address _____

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.