

FILED DEC 10 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41175

State File No. ....  
Registrar's No. .... 11363

BIRTH NO. .... 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)	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>ST. LOUIS, MISSOURI</b>		a. STATE <b>Missouri</b> b. COUNTY <b>2159</b>	
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <b>15 4110 Itaska ave.</b>		(If rural, give location)	
3. NAME OF DECEASED a. (First) <b>ALBERT</b> (Type or Print)		b. (Middle)	
c. (Last) <b>SLAVIK</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>NOVEMBER 30, 1953</b>	
5. SEX <b>0</b> <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>divorced 3</b>	8. DATE OF BIRTH <b>11-26-1889</b>
9. AGE (In years last birthday) <b>64</b>		10. MONTHS <b>0</b>	11. DAYS <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>barber</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Rock Creek, Mo. 0</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Micheal Slavik</b>	
13b. MOTHER'S MAIDEN NAME <b>Anna Kovarik</b>		14. NAME OF HUSBAND OR WIFE <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Frank Batek, House Springs, Mo.</b>		ADDRESS	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Dissecting aneurysm of aorta</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive cardiovascular disease</b> 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 checked="" 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) <b>443X</b>			
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?			
22. I hereby certify that I attended the deceased from <b>11-28-53</b> , 19 <b>53</b> , to <b>11-30-53</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>11-30-53</b> , 19 <b>53</b> , and that death occurred at <b>1:15A</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Ed. Taylor M.D.</b>		(Degree or title)	
23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>11-30-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>12-1-53</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>House Springs, Mo.</b>		24d. LOCATION (City, town; or county) (State)	
DATE REC'D BY LOCAL REG. <b>DEC 1 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Brimmer F.H., House Springs, Mo.</b>		ADDRESS	

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

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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.....  
Signature of Student Embalmer

Signed.....  
*J. Allen Davis*

Licensed Embalmer No. *4055*

P. O. Address *St. Louis*

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.