

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44692

State File No.

BIRTH REG. FILED DEC 29 1953 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 3235

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights		c. CITY OR TOWN Florissant d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. LENGTH OF STAY (In this place) 2 WKS.		e. STREET ADDRESS (If rural, give location) Route # 2 Box 357	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Matthew	c. (Last) Zykan	4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1953.
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 16, 1878	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hauling	10b. KIND OF BUSINESS OR INDUSTRY Drayage	11. BIRTHPLACE (City and State or Foreign Country) Florissant, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME William Zykan	13b. MOTHER'S MAIDEN NAME Emma Patterson	14. NAME OF HUSBAND OR WIFE Emma Zykan Dec'd.
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. 487-38-3347	17. INFORMANT'S SIGNATURE OR NAME Edward Zykan, Florissant, Mo.	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis Summary embolus Peptic ulcer etc		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 12/10/53	19b. MAJOR FINDINGS OF OPERATION Peptic ulcer (large)	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1952** to **death**, that I last saw the deceased alive on **12/17/53**, and that death occurred at **2:30 p.m.** from the causes and on the date stated above.

23a. SIGNATURE Edmund M. D. ...	(Degree or title)	23b. ADDRESS 4661 Linden	23c. DATE SIGNED 12/18/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/19/53	24c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	24d. LOCATION (City, town, or county) (State) Florissant, Mo.
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DATE REC'D BY LOCAL REG. 12/18/53	REGISTRAR'S SIGNATURE Heather B. ...	25. FUNERAL DIRECTOR'S SIGNATURE White Chapel, Ferguson, Mo.	ADDRESS
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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 *Eleana Poirice*

Licensed Embalmer No..3403.....

P. O. Address Jennings, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.