

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15382**
Registrar's No. **12061**

FILED JAN 19 1954

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY MISSOURI		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. CITY OR TOWN ST. LOUIS	
c. LENGTH OF STAY (In this place)		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 3245 OREGON		e. STREET ADDRESS (If rural, give location) 24 3245 OREGON	
3. NAME OF DECEASED (Type or Print) a. (First) PHILIP b. (Middle) JOVANOVICH c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) DEC. 21 1953	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 4-1886
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK CLERK	11. BIRTHPLACE (City and State or Foreign Country) YUGO SLAVIA
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY FAMOUS BARR	12. CITIZEN OF WHAT COUNTRY? 8
13a. FATHER'S NAME PHILIP JOVANOVICH		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE BARBARA JOVANOVICH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME BARBARA JOVANOVICH ADDRESS 3245 OREGON
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. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Coronary Thrombosis DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Patrick Playlar Chesner		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 12-22-53
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE DEC. 24 1953	24c. NAME OF CEMETERY OR CREMATORY NEW PICKER CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
DATE REC'D BY LOCAL REG. DEC 22 1953	REGISTRAR'S SIGNATURE Carol Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis ADDRESS 2906 Lewis	

(Licensed Embalmer's Statement on Reverse Side)

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

3

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 *Samuel C. Dill*

Licensed Embalmer No. *4347*
P. O. Address *2906 Grand*

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.