

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45436

FILED JAN 19 1954

State File No. 12034  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY <b>0</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>ST. LOUIS, MISSOURI</b> )		c. LENGTH OF STAY (in this place) <b>9 days</b>	c. CITY OR TOWN <b>St Louis</b>		d. Is 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 <b>BARNES HOSPITAL</b>			e. STREET ADDRESS (If rural, give location) <b>220 N. Kingshighway</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA</b> b. (Middle) <b>Hañousek</b> c. (Last) <b>MAX</b>			4. DATE OF DEATH <b>DECEMBER 21, 1953</b> (Month) (Day) (Year)		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov 15 1882</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Czecho-Slovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13a. FATHER'S NAME <b>Antonin Havlicek</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Poftecha</b>		14. NAME OF HUSBAND OR WIFE <b>C. O. C. Max</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. John F. Cusack, Chicago, Ill.</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CANCER OF THE BREAST</b>  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 <b>8 yrs</b>
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? <b>170X</b>			
22. I hereby certify that I attended the deceased from <b>12-12-</b> , 19 <b>53</b> , to <b>12-21-</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>12-21-</b> , 19 <b>53</b> and that death occurred at <b>3:35 A. m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Robt R. Bensch</b>		(Degree or title) <b>M. D.</b>	23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>12-21-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12-21-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	24d. LOCATION (City, town, or county) (State) <b>Bessemer, Mich.</b>		
DATE REC'D BY LOCAL REG. <b>DEC 21 1953</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H Hoppe</b> ADDRESS <b>4700 Washington Ave.</b>		

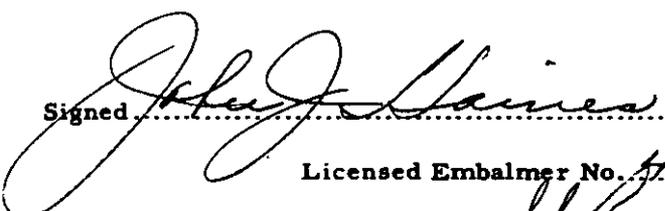
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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  .....

Licensed Embalmer No. 4108

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