No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10199

State File No.

BIRTH NO. FILED MAR 19 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2419

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Alexian Bros Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: 2159
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 15 4116 Taft Av

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): W
c. (Last): Kusmec

4. DATE OF DEATH (Month) (Day) (Year): March 15 1954

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 9 1899
9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Worker
10b. KIND OF BUSINESS OR INDUSTRY: Shoe Factory
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY?: U S A

13a. FATHER'S NAME: Charles Kusmec
13b. MOTHER'S MAIDEN NAME: Agnes Ban
14. NAME OF HUSBAND OR WIFE: Elizabeth

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: Elizabeth Kusmec
ADDRESS: 4116 Taft 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): Anemia — INTERVAL BETWEEN ONSET AND DEATH: 9 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive Cardio. vascular
~~DUE TO (c)~~: renal disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Cirrhosis of liver

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

442X

22. *I hereby certify that I attended the deceased from* 1-29, 1954, *to* 3-15, 1954, *that I last saw the deceased alive on* 3-15, 1954, *and that death occurred at* 1:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. D. Hoffmann (Degree or title) M.D.
23b. ADDRESS: 16 Houston Village Plaza
23c. DATE SIGNED: 3/16/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-19-54
24c. NAME OF CEMETERY OR CREMATORY: S S Peter & Paul Cem
24d. LOCATION (City, town, or county) (State): St Louis Missouri

DATE REC'D BY LOCAL REG.: MAR 16 1954
REGISTRAR'S SIGNATURE: J. Carl Smith MD
MDB
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Moydell Funeral Home 1926 Allen Av

(Licensed Embalmer's Statement on Reverse Side)

MAR 22 1954

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Reinhold K. Lohrmann

Signed.....
Student Embalmer

Licensed Embalmer No. 3395

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.