

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13680

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2951

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Marion Hospital</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u> b. (Middle) <u>George</u> c. (Last) <u>Kolar</u>		d. STREET ADDRESS (If rural, give location) <u>2337 A. Geyer Ave.,</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>12-28-173</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		9. AGE (In years last birthday) <u>80</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Rail-road</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	
13a. FATHER'S NAME <u>Joseph Kolar</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
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.		14. NAME OF HUSBAND OR WIFE <u>Julia Kolar</u>	
19a. DATE OF OPERATION		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Anna D. Kolar, 2337 A. Geyer Ave.,</u>	
19b. MAJOR FINDINGS OF OPERATION		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		MEDICAL CERTIFICATION	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Edema</u>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>151X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma, Esophageal, metastatic</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		DUE TO (c) _____	
21f. HOW DID INJURY OCCUR?		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Mar 30</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Mar 29</u> , 19 <u>54</u> , and that death occurred at <u>7 p.</u> m., from the causes and on the date stated above.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. SIGNATURE (Degree or title) <u>Des. A. Leib M.D.</u>		23b. ADDRESS <u>2323 Lafayette St. St. Louis</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23c. DATE SIGNED <u>3/30/54</u>	
24b. DATE <u>4-2-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Moydell Funeral Home, 1926 Allen Ave</u>	
DATE REC'D BY LOCAL REG. <u>APR 1 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed Reinhold K. Lehman

Licensed Embalmer No. 3395

P. O. Address.....

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

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