

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32443

State File No. _____
Registrar's No. 2027

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton, Missouri</u>		c. CITY OR TOWN <u>Valley Park</u> d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) <u>10 MIN.</u>		e. STREET ADDRESS (If rural, give location) <u>661 River Drive</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>			

3. NAME OF DECEASED a. (First) <u>Zigmund</u> b. (Middle) <u>R.</u> c. (Last) <u>Nagy</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 22 1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>March 7 1916</u>		9. AGE (In years last birthday) <u>38</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Airplane Parts Factory</u>		11. BIRTHPLACE (City and State/For Foreign Country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Zigmund Nagy</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Nagy</u>		14. NAME OF HUSBAND/OR WIFE <u>Jewell Nagy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Nil</u>		16. SOCIAL SECURITY NO. <u>279-09-7607</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Jewell Nagy, 5030 Delmar Blvd.</u>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Massive Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Laceration of Common Carotid?</u>			
		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchial Aspiration</u>					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Homicide</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Valley Park St. Louis Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>August 22 1954 3:03 p.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck in neck with a broken beer bottle during a scuffle</u>	

22. I hereby certify that I attended the deceased from 3:03 a.m. 8-22-54, to 8:22 p.m. 8-22-54, that I last saw the deceased alive on 8-22, 1954, and that death occurred at 3:43 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Malvin C. Kester, M.D.</u>		23b. ADDRESS <u>101 S. Beechwood</u>		23c. DATE SIGNED <u>8/24/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-24-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	
		24d. LOCATION (City, town, or county) (State) <u>Elyria, Ohio.</u>			

DATE REC'D BY LOCAL REG. <u>8/24/54</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Romke</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd</u>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
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.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

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)		23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
		24d. LOCATION (City, town, or county) (State)			

DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

WRITE PLAINLY—USING UNFADING BLACK INK

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 Guy W. Wilkinson.....

Licensed Embalmer No. 35

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.

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 Guy W. Wilkinson.....

Licensed Embalmer No. 35

P. O. Address M. Lane.....

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.