

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **39075**
9613

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Ann's		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3911 Cottage Ave.,				e. STREET ADDRESS (If rural, give location) 789 Adie Road, St. Ann's Mo.,			
3. NAME OF DECEASED (Type or Print) MARTIN		a. (First)		b. (Middle)		c. (Last) NOVAK	
4. DATE OF DEATH Oct. 22-1954		(Month)		(Day)		(Year)	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 22-1915	
9. AGE (In years last birthday) 39		If UNDER 1 YEAR Months _____ Days _____		If UNDER 1 YEAR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Welder		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Scedell Novak			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Scedell Novak ADDRESS 789 Adie Road, St. Anna, Mo.,			
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sulcoicite Disseminated Lupus erythematosus INTERVAL BETWEEN ONSET AND DEATH 4 1/2 mo			
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 now		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 456X			
22. I hereby certify that I attended the deceased from July 12th, 1954 , to Oct 22nd, 1954 , that I last saw the deceased alive on Oct 22nd, 1954 , and that death occurred at 2:00 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE Dr. M. J. Shave M.D.		(Degree or title)		23b. ADDRESS 4500 Olive St. St. Louis		23c. DATE SIGNED 10/23/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 25-1954		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.,	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 23 1954		REGISTRAR'S SIGNATURE Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Leidner Und. Co., ADDRESS 2223 St. Louis Ave.,			

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *W. W. Wilkinson*

Licensed Embalmer No..... 3

P. O. Address..... *M. Lou*

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.