

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

42647

State File No. ....

10771

Registrar's No. ....

**FILED DEC 16 1954**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>22290</b>	
b. CITY OR TOWN <b>St Louis</b>		c. CITY OR TOWN <b>St Louis</b>	
c. LENGTH OF STAY (in this place)		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 <b>St. Louis City Hospital #1</b>		e. STREET ADDRESS (If rural, give location) <b>22 926 Morrison Av</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>THERESA</b>		a. (First) b. (Middle) c. (Last) <b>MORTIKA</b>	
<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov. 24 1954</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>May 18 1874</b>
<b>9. AGE</b> (in years last birthday) <b>80</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Hungary 4</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13a. FATHER'S NAME</b> <b>Michael Kapacala</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Theresa</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Peter (Deceased)</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>John Mortika</b>		<b>ADDRESS:</b> <b>1317 Woodruff Pagedale</b>	
<b>18. CAUSE OF DEATH.</b> 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.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)</b> <b>Bacterial Pneumonia (On Neck) (Red)</b> <b>ANTECEDENT CAUSES</b> <b>Due to (b)</b> <b>Bronchiectasis</b> <b>Due to (c)</b> <b>II. OTHER SIGNIFICANT CONDITIONS</b> <b>Cerebral Vascular Accident</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT</b> (Specify) <b>SUICIDE</b> <b>HOMICIDE</b>		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>21c. (CITY, TOWN, OR TOWNSHIP)</b> (COUNTY) (STATE)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>		<b>526K</b>	
<b>22. I hereby certify that I attended the deceased from 11-12, 1954, to 11-24, 1954, that I last saw the deceased alive on 11-24, 1954, and that death occurred at 1:25 P.m., from the causes and on the date stated above.</b>			
<b>23a. SIGNATURE</b> (Degree or title) <b>John R. Baigian MD</b>		<b>23b. ADDRESS</b> <b>1515 Lafayette Ave.</b>	
<b>23c. DATE SIGNED</b> <b>11-26-54</b>			
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24b. DATE</b> <b>11/27/54</b>	
<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>S. S. Peter &amp; Paul Cem</b>		<b>24d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Missouri</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>NOV 26 1954</b>		<b>REGISTRAR'S SIGNATURE</b> <b>J. Carl Smith MD</b>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Moydell Funeral Home</b>		<b>ADDRESS</b> <b>1926 Allen Av</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 *R. Reinhold K. Lohman*

Licensed Embalmer No. *339*

P. O. Address *St. Louis*

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.