

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13546**
3561

FILED APR 28 1955

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 _____	
b. CITY (If outside corporate limits, write RURAL and give zip) OR TOWN ST. LOUIS MO		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		e. STREET ADDRESS (If rural, give location) 2249 3820 TEXAS	

3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) - c. (Last) KLASEK	4. DATE OF DEATH (Month) (Day) (Year) APRIL 19 1955
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JULY 26 1874	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHOE WORKER	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? U-S-A
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13a. FATHER'S NAME MICHAEL KLASEK	13b. MOTHER'S MAIDEN NAME ANNA KRISTOF	14. NAME OF HUSBAND/OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME CORA KLASEK	ADDRESS 3820 TEXAS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pyelonephritis 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 checked="" 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) _____
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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? 6000
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22. I hereby certify that I attended the deceased from **March**, 19**51**, to **April**, 19**55**, that I last saw the deceased alive on **April 19, 1955**, and that death occurred at **11:00 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Marion W. Dancy M.D.	(Degree or title) _____	23b. ADDRESS 539 N. Grand	23c. DATE SIGNED 4/21/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE APR 22 1955	24c. NAME OF CEMETERY OR CREMATORY S.S. PETER & PAUL CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. APR 21 1955	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis	ADDRESS 2906 Beavercreek
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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 *Samuel C. Hill*.....

Licensed Embalmer No. *434*
P. O. Address *2906*.....

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.