

FILED MAY 31 1955

STANDARD CERTIFICATE OF DEATH

DR. TSANG

15187

State File No.

BIRTH NO.		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 464				
1. PLACE OF DEATH a. COUNTY GREENE b. CITY (If outside corporate limits, write RURAL and give town or TOWN SPRINGFIELD) c. LENGTH OF STAY (In this place) 2 WKS d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY COOK c. CITY OR TOWN WEST CHESTER d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) 10261 DICKENS 8128						
3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) c. (Last) MAROVIC			4. DATE OF DEATH (Month) (Day) (Year) MAY 24 1955		5. SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>		6. COLOR OR RACE WHITE			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH FEB. 2 1896		9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAVERN OPERATOR			10b. KIND OF BUSINESS OR INDUSTRY TAVERN OPERATOR		11. BIRTHPLACE (City and State or Foreign Country) YUGOSLAVIA 8		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME JOSEPH MAROVIC			13b. MOTHER'S MAIDEN NAME BARBARA KRALL			14. NAME OF HUSBAND OR WIFE JOSEPHINE MAROVIC				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. JOSEPHINE MAROVIC WEST CHESTER, ILL.					
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>Rupture of brain</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Compound comminuted depressed skull fracture</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. E8234 32						INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION 5-17-55		19b. MAJOR FINDINGS OF OPERATION Rupture of brain				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT (Specify) SUICIDE HOMICIDE <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Road Hwy #14		21c. (CITY, TOWN, OR TOWNSHIP) 106 (COUNTY) (STATE) Just outside Branson, Hany County, Missouri		21f. HOW DID INJURY OCCUR? Car skidded off Road.				
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 5-10-55 m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22. I hereby certify that I attended the deceased from 5-17, 1955, to 5-23, 1955, that I last saw the deceased alive on 5-23, 1955, and that death occurred at 5A. m., from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <u>John P. Tsang M.D.</u>			23b. ADDRESS 609 Cherry Springfield, Mo			23c. DATE SIGNED 5-24-55				
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 5/25/55		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) CHICAGO, ILLINOIS				
DATE REC'D BY LOCAL REG. 5-25-55		REGISTRAR'S SIGNATURE <u>Gaith Williamson</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>John Tsang</u>		ADDRESS SPRINGFIELD, MO.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 28 1955

JUN 24 1955

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 *Gene C. Hunter*.....

Licensed Embalmer No. *473*

P. O. Address *Springfield*

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.