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FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28212

State File No. ....

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 7005

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS MO</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LITTLE FLOWER RETREAT</u>		STREET ADDRESS (If rural, give location) <u>5073 CHIPPEWA</u>	
3. NAME OF DECEASED a. (First) <u>WILLIAM</u> b. (Middle) <u>SVOBODA</u> c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 6 1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR 4 1881</u>
9. AGE (In years last birthday) <u>74</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>BOHEMIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JOSEPH SVOBODA</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MARY SVOBODA (DEC'D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>LILLIAN OTTO</u>		ADDRESS <u>6010 LANS DOWNE</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myelogenous Leukemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterio Sclerosis - Senility</u> <u>2 yrs +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>2041</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 <u>8/14</u> , 19 <u>55</u> , to <u>8/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/6</u> , 19 <u>55</u> , and that death occurred at <u>10-P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Hubert P Smith</u> (Degree or title)		23b. ADDRESS <u>2259 5203 Chipewa Dr</u>	
23c. DATE SIGNED <u>8/8/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG 11 1955</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>S. J. PETER &amp; PAUL</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>AUG 10 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kates</u>		ADDRESS <u>2906 Prairie</u>	

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

12-4 PM Thursday  
PR 2-5200

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.....  
*Thomas C. Hill*

Licensed Embalmer No. *434*

P. O. Address *2906*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.