

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **31119**  
**7641**  
Registrar's No. ....

BIRTH NO. ....		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. ....			
<b>1. PLACE OF DEATH</b> a. COUNTY  b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b> c. LENGTH OF STAY (In this place)  d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY c. CITY OR TOWN <b>St. Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <b>13 5100 Arsenal St.</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Rade</b>		a. (First)		b. (Middle)		c. (Last) <b>Korda</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Widower</b>		<b>8. DATE OF BIRTH</b> <b>May 1871</b>			
<b>9. AGE</b> (In years last birthday) <b>84</b>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>					
<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Serbia</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>13a. FATHER'S NAME</b> <b>Paul Korda</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Emelia ?</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Angelina Korda</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknowns) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS					
<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, asthma, etc. It means the disease, injury, or complication which caused death.				<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Arteriosclerosis heart disease</b>  ANTECEDENT CAUSES DUE TO (b) <b>Conjestive failure</b> DUE TO (c) <b>pneumonitis</b>  <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.				<b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>One half hour</b>  <b>2 weeks</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>  <b>420.0</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>					
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from May 1953, 19, to 8-21-1955, that I last saw the deceased alive on 8-21, 1955, and that death occurred at 4:10 p. m., from the causes and on the date stated above.</b>									
<b>23a. SIGNATURE</b> (Degree or title) <b>in D O</b>				<b>23b. ADDRESS</b> <b>5100 Arsenal Street</b>		<b>23c. DATE SIGNED</b> <b>8-24-55</b>			
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>24b. DATE</b> <b>AUG 31 1955</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Anatomical Board</b>		<b>24d. LOCATION (City, town, or county) (State)</b> <b>St. Louis, Mo.</b>			
<b>DATE REC'D BY LOCAL REG.</b> <b>AUG 31 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>J. Carl Smith M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Howland-Aker Mortuary Service</b> <b>1104 Manchester Ave.</b> <b>St. Louis 10, Mo.</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.....

Licensed Embalmer No.....

P. O. Address.....

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.