

FILED OCT 24 1955

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

35093

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8873**

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|--|--|--|--|----------------------------------|--|
| 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 township) OR TOWN ST. LOUIS, MISSOURI | | c. LENGTH OF STAY (in this place) | | c. CITY OR TOWN ST. LOUIS | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL | | e. STREET ADDRESS (If rural, give location) 3 6247 COLUMBIA 2039 | | | |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) Wenceslaus c. (Last) RATAJ | | | 4. DATE OF DEATH OCT. 8, 1955 (Month) (Day) (Year) | | |
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|--------------------|--|-------------------------------|--|--|--|---------------------------------------|--|---|--|----------------------------------|--|----------------------------------|--|
| 5. SEX Male | | 6. COLOR OR RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH SEPT. 12 1871 | | 9. AGE (In years last birthday) 84 | | 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 SADDLE MAKER | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (City and State or Foreign Country) CZECHOSLOVAKIA | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
|---|--|--|-----------------------------------|--|--|--|--|--|--|--|--|

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| 13a. FATHER'S NAME VACLAV RATAJ | | | 13b. MOTHER'S MAIDEN NAME KATHERINE Nosek | | | 14. NAME OF HUSBAND OR WIFE ANNA RATAJ (Dec'd) | | |
|--|--|--|--|--|--|---|--|--|

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|--|--|-------------------------------------|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME JOSEPH RATAJ ADDRESS 6247 COLUMBIA | | | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Rectum 2 yrs | | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

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|------------------------|--|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 154x | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (m.) | | | | 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 **9-29**, 19**55**, to **10-8**, 19**55**, that I last saw the deceased alive on **10-8**, 19**55**, and that death occurred at **6:15p m.**, from the causes and on the date stated above.

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|---|--|--|---|--|----------------------------------|--|
| 23a. SIGNATURE James W Hurley MD (Degree or title) | | | 23b. ADDRESS 1515 LAFAYETTE A.E. | | 23c. DATE SIGNED 10-10-55 | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE OCT 11 1955 | | 24c. NAME OF CEMETERY OR CREMATORY RESURRECTION | | 24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo | |
|---|--|------------------------------|--|--|--|---|--|

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| DATE REC'D BY LOCAL REG. OCT 11 1955 | | REGISTRAR'S SIGNATURE J. Cash Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kuttis ADDRESS 2906 Shawnee | |
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(Licensed Embalmer's Statement on Reverse Side)

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 L*

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.