

FILED JAN 26 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 585  
Registrar's No. 585

BIRTH NO. 10163-56 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis,	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarnate Word Hosp.		e. STREET ADDRESS (If rural, give location) 17 2925 Geyer Ave. 21790	

3. NAME OF DECEASED (Type or Print) a. (First) Jo Ann b. (Middle) Komadina c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 1/17/56		
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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 1/16/56		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 1 IF UNDER 14 HOURS 4 IF UNDER 14 MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Joseph Komadina		13b. MOTHER'S MAIDEN NAME Anna Marie McDonald		14. NAME OF HUSBAND OR WIFE none	
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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) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joseph Komadina 2925 Geyer Ave.		
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES DUE TO (b) Tentorial tear DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 760:0			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)	
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 1-16-56, 19, to 1-17-56, 19, that I last saw the deceased alive on 1-17-56, 19, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE John P. Lynn M.D. (Degree or title)		23b. ADDRESS 1716 So 39th St. St. Louis, Mo.	23c. DATE SIGNED 1-18-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/17/56	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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DATE REC'D BY LOCAL REG. JAN 18 1956	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette Ave.		
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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

NO EMBALMING

Signed..... *E. J. Schmitt* .....  
Licensed Embalmer No.....

P. O. Address...3125 Lafayette

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.