

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 29 1956

State File No. 21884

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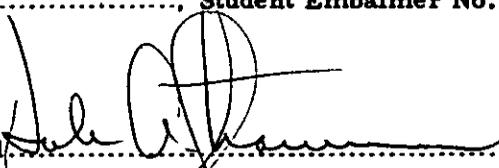
BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>9</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6419 Quincy St.</u>				e. STREET ADDRESS (If rural, give location) <u>6419 Quincy St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALBERT</u>		b. (Middle) <u>A.</u>		c. (Last) <u>HLUZEK SR.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 16 1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 16, 1900</u>	
9. AGE (In years last birthday) <u>56</u>		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) <u>Upholsterer-Koken</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Inc.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>House Springs, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph Hluzek</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Chott</u>			14. NAME OF HUSBAND OR WIFE <u>Della Hluzek</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Della Hluzek 6419 Quincy St.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u> ANTECEDENT CAUSES DUE TO (b) <u>Rheumatic heart disease</u> 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 <u>instant</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) <u>4/16x</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>6-1-56</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>1952 6-16-56</u>			
22. I hereby certify that I attended the deceased from <u>1952</u> to <u>4/16/56</u> , that I last saw the deceased alive on <u>4/16/56</u> , and that death occurred at <u>3:05 p.</u> m., from the causes and on the date stated above <u>6-18-56</u>							
23a. SIGNATURE <u>Dallas J. Byer</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>3615 Watson</u>		23c. DATE SIGNED <u>4/18/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Mtr)</u>		24b. DATE <u>6-19-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Philomena's Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>House Springs, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUN 18 1956</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</u>			

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 

Licensed Embalmer No. 4533

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.