

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **32737**

FILED SEP 19 1956

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2040**

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

1. PLACE OF DEATH a. COUNTY St. Louis		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) Gardenville		c. LENGTH OF STAY (in this place) 6 WKS	
c. CITY (If outside corporate limits, write RURAL and give township) St Louis		d. STREET ADDRESS (If rural, give location) 2413 a So 18th St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Miller Nursing Home		3. NAME OF DECEASED a. (First) Michael b. (Middle) _____ c. (Last) Drska (Driska) Sr.	
4. DATE OF DEATH (Month) (Day) (Year) Aug 27 1956		5. SEX Male 6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sept 29, 1879	
9. AGE (in years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truckman	
11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME Paul Drska		13b. MOTHER'S MAIDEN NAME Elizabeth Michalcek	
14. NAME OF HUSBAND OR WIFE Anna		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. unth.		17. INFORMANT'S SIGNATURE OR NAME Anna Drska	
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arterio Sclerosis 5 mile changes ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intestinal Obstruction DUE TO (c) due to Carcinoma Lower Sigmoid II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Decompression calcostomy	
19a. DATE OF OPERATION May 20/56		19b. MAJOR FINDINGS OF OPERATION Done on May 20/56	
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)		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 May 20, 1956 , to 8/2/56 , that I last saw the deceased alive on 8/2/56 , and that death occurred at 1:05 Am. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Edward J. Jordan M.D.		23b. ADDRESS 1504 South Grand	
23c. DATE SIGNED 8/28/56		24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 8/30/56		24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Herbert A. Hombe	
DATE/REC'D BY LOCAL REG. 8/29/56		ADDRESS Moynell Funeral Home 1926 Allen Ave	

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 _____

..... *me* Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed *George Svoboda Jr*
Licensed Embalmer No. *4899*

P. O. Address *1926 Allen Ave*

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 this body is not embalmed, fact should be so stated above.