FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

35254

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9282

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

**1. PLACE OF DEATH**
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3444a Pennsylvania Av

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN: St Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐

e. STREET ADDRESS (If rural, give location): 3444a Pennsylvania Av

**3. NAME OF DECEASED** (Type or Print)
a. (First): Barbara
b. (Middle): Marie
c. (Last): Benda

**4. DATE OF DEATH** (Month) (Day) (Year): Oct 10 1956

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Widowed
**8. DATE OF BIRTH**: Feb 20 1870
**9. AGE** (In years last birthday): 86 — 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): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**
**11. BIRTHPLACE** (City and State or Foreign Country): Czechoslovakia
**12. CITIZEN OF WHAT COUNTRY?**: U S

**13a. FATHER'S NAME**: Frank Masek
**13b. MOTHER'S MAIDEN NAME**: Barbara Burian
**14. NAME OF HUSBAND OR WIFE**: John (Deceased)

**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.**
**17. INFORMANT'S SIGNATURE OR NAME** ADDRESS: Mollie Benda Corless 3444a Penn Av

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 Days

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Paralysis Agitans — 4-5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.* None

**19a. DATE OF OPERATION**: None
**19b. MAJOR FINDINGS OF OPERATION**: 420.1
**20. AUTOPSY?** YES ☐ NO ☑

**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 ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Sept 25, 1956, *to* 10/10, 1956, *that I last saw the deceased alive on* 10/10, 1956, *and that death occurred at* 2:45 a.m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): Dr Paul H. Halbert MD
**23b. ADDRESS**: 2905 Chesaber-Whiting Bldg
**23c. DATE SIGNED**: 10/10/56

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: 10/12/56
**24c. NAME OF CEMETERY OR CREMATORY**: New Picker Cemetery
**24d. LOCATION** (City, town, or county) (State): St Louis Missouri

**DATE REC'D BY LOCAL REG.**: OCT 11 1956
**REGISTRAR'S SIGNATURE**: Earl Smith MD
**25. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Mondell Funeral Home 1926 Allen Av

MJB

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was eml

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Reinhold K Lohrm

Licensed Embalmer No. 33

P. O. Address St Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.