

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39502

STATE FILE NUMBER

FILED NOV 28 1956

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **10139**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>JEWISH Hosp.</b>			Length of stay in lb		d. STREET ADDRESS <b>3430 S. SPRING</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>JANAUSCHEK</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1956</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 28 1870</b>		
9. AGE (In years less birth day) <b>86</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>6</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRESSMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>MISSISSIPPI COMM.</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>	
13. FATHER'S NAME <b>WILLIAM JANAUSCHEK</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
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. <b>NONE</b>		17. INFORMANT <b>JOSEPH W. JANAUSCHEK</b> Address <b>3430 S. SPRING</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - rt</b> DUE TO (b) <b>Carcinoma of Prostate</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>?</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>Day, Year</b> p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <b>10-31-56</b> to <b>11-5-56</b> and last saw <sup>her</sup> him alive on <b>11-4-56</b> Death occurred at <b>1 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Edward J Berger MD.</b>				22b. ADDRESS <b>457N. KINGSHIGHWAY</b>		22c. DATE SIGNED <b>11-6-56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Nov. 7 1956</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>		
24. FUNERAL DIRECTOR <b>Thomas Kuts 2906</b>			25. DATE RECD. BY LOCAL REG. <b>NOV 7 1956</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>m. J. B.</b>			

MEDICAL CERTIFICATION

Doctor, coroner, or other person certifying in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

(Licensed Embalmer's Statement on Reverse Side)

11-11-11  
7

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 *Leaf Budd* .....  
Licensed Embalmer No. *39* .....  
P. O. Address *St. Louis* .....

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