

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14912

STATE FILE NUMBER

FILED MAY 10 1957

318

1003

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **4067**

Health, Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases 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

| | | | | | | | | |
|---|--|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb 25 ST. LOUIS CITY HOSP. # 1. | | | | d. STREET ADDRESS (If outside, give location) 3744 St. Louis Ave. | | | | |
| 3. NAME OF DECEASED (Type or print) DAMIAN ^{First} KOVACEVIC ^{Last} | | | | 4. DATE OF DEATH APRIL 29, 1957 ^{Month Day Year} | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 21, 1871 | | |
| 9. AGE (In years last birthday) 85 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Coal Co. | | 11. BIRTHPLACE (City and state or country) Yugoslavia | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | |
| 13. FATHER'S NAME Michael Kovacevic | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 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 Anthony Kovace Address 3744 St. Louis Ave | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction arterio sclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) 420.0 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 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 Month, Day, Year a. m. 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 4/22/57 to 4/29/57 and last saw her ^{her} ^{him} alive on 4/29/57 . Death occurred at 5:30 A.M on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>[Signature]</i> M.D. | | | | 22b. ADDRESS 1515 LAFAYETTE AVE. | | 22c. DATE SIGNED 4/29/57. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 4-29-57 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) (State) Madison Illinois | | |
| 24. FUNERAL DIRECTOR John L. Sedlack | | | ADDRESS Madison, Illinois | | 25. DATE RECD. BY LOCAL REG. APR 29 57 | | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> 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 embalmed ^{NOT} by me, or by, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *John T Sedlack*

Licensed Embalmer No. *3747*

P. O. Address *MADISON*

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.