

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18946**
Registrar's No. **5104**

FILED JUN 7 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY							
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3 days		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.				e. STREET ADDRESS (If rural, give location) 2239 2004 S. 12th St.							
3. NAME OF DECEASED (Type or Print) Jacob Krpan			a. (First)		b. (Middle)		c. (Last)				
4. DATE OF DEATH (Month) (Day) (Year) 5 31 1957		5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Abt 1879			
9. AGE (In years last birthday) Abt 78		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours		IF UNDER 15 MIN. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Labor				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and State or Foreign Country) Austria		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME Pete Krpan			13b. MOTHER'S MAIDEN NAME Anna ?			14. NAME OF HUSBAND OR WIFE Mary ?					
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.			17. INFORMANT'S SIGNATURE OR NAME Mary Krpan			ADDRESS 2004 S 12th Street		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</p>				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Pt. Adenocarcinoma						2 yrs.	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 163x							
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Arteriosclerotic Heart Disease						2 yrs.	
19a. DATE OF OPERATION 4/11/55		19b. MAJOR FINDINGS OF OPERATION Pt. Upper Lobectomy - Adenocarcinoma Lung.						20. AUTOPSY? 1 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) (Min.)		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 5-28-57 , 19____, to 5-31-57 , 19____, that I last saw the deceased alive on 5-31-57 , 19____, and that death occurred at 6:55 a.m. , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.				23b. ADDRESS 5800 Arsenal St.				23c. DATE SIGNED 6/31/57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6/4/57		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery - St. Louis County Mo		24d. LOCATION (City, town, or county) (State)					
DATE REC'D BY LOCAL REG. MAY 31 1957		REGISTRAR'S SIGNATURE J. Earl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE Moynell Funeral Home				ADDRESS 1926 Allen Ave	

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 me....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed George Luboda.....

Licensed Embalmer No. 489

P. O. Address 1926 Allen

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.