

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33739

STATE FILE NUMBER

8375

FILED SEP 17 1957

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No.

|  |  |   |  |   |   |  |  |   |  |
|--|--|---|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |   |  |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St Louis</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                 |  | c. CITY<br>OR<br>TOWN <b>St Louis</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>Lutheran Hospital</b>   |  |   | Length of stay in lb<br><b>3dys</b>  |   | d. STREET (If outside, give location)<br>ADDRESS <b>910 Geyer Ave</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Frances</b> Last <b>Kochis (Kocis)</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept</b> Day <b>5</b> Year <b>1957</b>   |   |  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>March 7 1876</b>  |  | 9. AGE (In years last birthday)<br><b>81</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>Czechoslovakia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>? Hudak</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Address<br><b>Cecelia Kane 4435 A Oakland Ave</b>    |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Cardio-Vascular Disease - Hypertension - Arteriosclerosis</b><br>DUE TO (c) |  |   |  |   |   |  |  | 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)<br><b>443x</b>  |  |   |  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Hour Month, Day, Year<br>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 <b>Oct 10, 1956 to Sept 5, 1957</b> and last saw her alive on <b>Sept 4, 1957</b><br>Death occurred at <b>7 17</b> m on the date stated above; and to the best of my knowledge, from the causes stated.   |  |   |  |   |   |  |  |   |  |
| 22a. SIGNATURE<br><b>A. P. Blas M.D.</b>   |  |   |  | 22b. ADDRESS<br><b>3150 Morganford Rd</b>   |   |  | 22c. DATE SIGNED<br><b>9/5/57</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City, town, or county)  |  | (State)   |  |
| <b>Burial</b>  |  | <b>9/7/57</b>   |  | <b>S S Peter &amp; Paul Cem</b>   |   | <b>St Louis Missouri</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Moydell Funeral Home 1926 Allen Av</b>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>SEP 6 57</b>   |   | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith M.D.</b>                                  |  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 *Reinhold K. Lohm* .....

Licensed Embalmer No. *93*

P. O. Address *H. Lou* .....

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.