THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33745

STATE FILE NUMBER 8132

FILED SEP 17 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hosp. #1 — Length of stay in 1b 25	d. STREET ADDRESS (If outside, give location) 3643 Dover Pl., 20/ — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First / Middle / Last: Julia Kovacic			4. DATE OF DEATH Month Day Year: 8/29/57	
5. SEX: Female	6. COLOR OR RACE: W.	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH (Mo. Day Year): May 22 1890	9. AGE (In years last birthday): 67 — 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): House Work	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (City and state or country): Jugoslavia		12. CITIZEN OF WHAT COUNTRY?: U S
13a. FATHER'S NAME: Unknown	13b. MOTHER'S MAIDEN NAME: Unknown	14. NAME OF HUSBAND OR WIFE: Chris		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. —	17. INFORMANT: Chris Kovacic	Address: 3643 Dover Place	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) THROMBOSIS OF (L) MIDDLE CEREBRAL A.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332 X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 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 7/31/57, to 8/29/57 and last saw her/him alive on 8/29/57. Death occurred at 1:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. M. Woolsey M.D.	22b. ADDRESS: 1515 Lafayette Ave.	22c. DATE SIGNED: 8/29/57

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9/3/57	23c. NAME OF CEMETERY OR CREMATORY: SS PETER & PAUL CEMETERY	23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: MOYDELL FUNERAL HOME	ADDRESS: 1926 ALLEN	25. DATE RECD. BY LOCAL REG.: AUG 30 57
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.R.		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed George J. Svoboda Jr

Licensed Embalmer No. 4899

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.