

FILED OCT 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38141**
Registrar's No. **9880**

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

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 23	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION 26 St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 231 2048 Russell	

3. NAME OF DECEASED (Type or Print) Rudolph Selakovich		4. DATE OF DEATH (Month) (Day) (Year) Oct. 20, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Abt. 1875
9. AGE (In years last birthday) Abt 82		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Rudolph	13b. MOTHER'S MAIDEN NAME May ?	14. NAME OF HUSBAND OR WIFE
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. 492-22-7427A	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Max Jakovac 1313 Ann

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Capillary Adenocarcinoma of Stomach		DUE TO (b) _____		8 mths.
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		151K		

19a. DATE OF OPERATION 9/11/57	19b. MAJOR FINDINGS OF OPERATION Capillary Gastrostomy + Biopsy Adenocarcinoma of Stomach		20. AUTOPSY? 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 **10/2/57**, 19____, to **Oct. 20**, 19 **57**, that I last saw the deceased alive on **Oct. 20**, 19 **57**, and that death occurred at **10:20 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	23c. DATE SIGNED 10/21/57
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/23/57	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope
24d. LOCATION (City, town, or county) (State) County Mo.		

DATE REC'D BY LOCAL REG. OCT 22 57	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen
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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. Lehmann*

Licensed Embalmer No. *3395*

P. O. Address *St. Louis*

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.