

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41713**

FILED NOV 20 1957

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10446**

|  |                               |   |  |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b><br>b. COUNTY  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>  |                               | c. CITY OR TOWN <b>St. Louis</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>01 713a Carroll St.</b>   |                               | e. STREET ADDRESS (If rural, give location) <b>22370 713a Carroll St.</b>   |  |
| 3. NAME OF DECEASED (Type or Print) <b>PAUL</b><br>a. (First) b. (Middle) c. (Last) <b>BAKITZ</b>  |                               | 4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 2, 1957</b>   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   | 8. DATE OF BIRTH <b>May, 15, 1892</b>                                |
| 9. AGE (In years last birthday) <b>65</b>  |                               | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and State or Foreign Country) <b>Yugoslavia</b> |
| 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |                               | 13a. FATHER'S NAME <b>Mita Bakitz</b>   |  |
| 13b. MOTHER'S MAIDEN NAME <b>Mace Todorovich</b>   |                               | 14. NAME OF HUSBAND OR WIFE <b>Mary Bakitz</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <b>498-07-4054</b>  |  |
| 17. INFORMANT'S SIGNATURE OR NAME <b>Mary Bakitz</b>   |                               | ADDRESS <b>713a Carroll St.</b>   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                                  |                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b><br><b>CORONARY OCCLUSION</b><br><b>Hypertension</b><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>HYPERTENSION</b><br>DUE TO (c) <b>4201</b> |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 MIN</b><br><b>3 YEARS</b>   |  |
| 19a. DATE OF OPERATION   |                               | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY? <b>2</b><br>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 <b>Oct 28, 1957</b> , to <b>Nov 2, 1957</b> , that I last saw the deceased alive on <b>NOV 2, 1957</b> , and that death occurred at <b>6:30 P.M., 6:30 AM</b> , on the date and on the date stated above. |                               |   |  |
| 23a. SIGNATURE <b>Willard I. Nash</b> <b>Willard I. Nash</b> D.O. (Degree or title) <b>D.O.</b>  |                               | 23b. ADDRESS <b>1829 S. 18th</b> <b>1829 S 18 ST</b>  |  |
| 23c. DATE SIGNED <b>11/4/57</b>  |                               |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>   |                               | 24b. DATE <b>11/5/57</b>  |  |
| 24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>  |                               | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>  |  |
| DATE REC'D BY LOCAL REG. <b>NOV 5 57</b>   |                               | REGISTRAR'S SIGNATURE <b>Carl Smith</b>   |  |
| 25. FUNERAL DIRECTOR'S SIGNATURE <b>CHULICK UND. CO.</b>   |                               | ADDRESS <b>1722 S. Jefferson</b>  |  |

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

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Harvey Kahle*

Licensed Embalmer No. 4596

P. O. Address *Flourent*

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.