

Health,  
& Welfare  
Public  
Service

S. 300  
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 27 1957

STANDARD CERTIFICATE OF DEATH

42269

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11077**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3225 Minnesota</b>		Length of stay in 1b	STREET ADDRESS <b>3225 Minnesota Av.</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>KATE</b> Middle <b>LOIDA</b> Last			4. DATE OF DEATH Month <b>11</b> Day <b>18</b> Year <b>'57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-1870</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Falout</b>			14. MOTHER'S MAIDEN NAME <b>Medek</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>J.L. LOIDA - Box 392, Creve Coeur Mo</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Myocarditis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>420.1</b>
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. Hour a. m. p. m.	20d. PLACE OF INJURY (e. g., in or about home, for m., factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		
21. I attended the deceased from <b>9/11/57</b> to <b>11/19</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>11/10/57</b> Death occurred at <b>5:00 p. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Chas. P. Hanson M.D.</b>			22b. ADDRESS <b>3012 Lafayette</b>		22c. DATE SIGNED <b>11/19/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-21-'57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Pk.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>		
24. FUNERAL DIRECTOR <b>MOYDELL FUNERAL HOME-1926 ALLEN</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>NOV 19 57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	

(Licensed Embalmer's Statement on Reverse Side)

m y b

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 Svoboda Jr.  
Licensed Embalmer No. 489

P. O. Address 1926 Alle

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.