

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3396

STATE FILE NUMBER 229

FILED JAN 17 1958

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 <i>Mo</i> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis Mo</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Little Sisters of Poor</i>				Length of stay in lb		STREET ADDRESS <i>2618 1508 B Salisbury</i>	
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>J</i> Last <i>Novak</i>				4. DATE OF DEATH Month <i>1</i> Day <i>8</i> Year <i>1958</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-15-1878</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>79</i>	
13. FATHER'S NAME <i>Valentine Novak</i>				14. MOTHER'S MAIDEN NAME <i>Maggie Hejdeck</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>493-07-8189</i>		17. INFORMANT Address <i>Edwin J. Koch - 3516 N. 14th</i>	
18. CAUSE OF DEATH [Enter only one cause per list (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis or hemorrhage</i> DUE TO (b) <i>A.S.H. Disease</i> DUE TO (c) <i>420.0 H</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of Prostate</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>???</i>	
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 <i>5</i> Month <i>5</i> Day <i>5</i> Year <i>1958</i> 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 <i>May 12, 1957</i> and last saw <i>her</i> alive on <i>Jan 4, 1958</i> Death occurred at <i>5</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Director or title) <i>Bernard H. Hottel M.D.</i>				22b. ADDRESS <i>2435 N. Grand Blvd</i>		22c. DATE SIGNED <i>1-8-58</i>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1-10-1958</i>		<i>Calvary Cemetery</i>		<i>St. Louis Mo</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Edw Koch & Son - 3516 N. 14th</i>				25. DATE RECD. BY LOCAL REG. <i>JAN 8 '58</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare Public Service
300
1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.....
Gustav W. Dieterle

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.