

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007657
State File No.

FILED MAR 5 - 1958

318

1003

2153
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. LENGTH OF STAY (In this place) 19 Yrs 1 Mo 23 Ds		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital.				e. STREET ADDRESS (If rural, give location) 3546 IOWA AVE			
3. NAME OF DECEASED (Type or Print) a. (First) Frank		b. (Middle) _____		c. (Last) Pesek		4. DATE OF DEATH (Month) (Day) (Year) February 20-1958.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH MAY 21 1880	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DAY LABORER		11. BIRTHPLACE (City and State or Foreign Country) Bohemia		12. CITIZEN OF WHAT COUNTRY? U-S-A	
13a. FATHER'S NAME Frank Pesek		13b. MOTHER'S MAIDEN NAME Mena		14. NAME OF HUSBAND OR WIFE MARY PESEK			
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. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MARY PESEK 3546 IOWA AVE			
18. CAUSE OF DEATH Enter only one cause per line for (a); (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bulmonary Congestion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive H.S. Failure DUE TO (c) Arteriosclerotic H.S. Disease				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week 5 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.0				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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 December 20-1938 Feb. 20, 1958 , that I last saw the deceased alive on Feb. 20, 1958 , and that death occurred at 5:05 P.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 2/21/58	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE FEB 24 1958		24c. NAME OF CEMETERY OR CREMATORY NEW PICKER CEM		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REG. 1 FEB 24 '58		REGISTRAR'S SIGNATURE Charles Smith		25. FUNERAL DIRECTOR'S SIGNATURE McThomas Nutie		ADDRESS 2906 Gravois	

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 *Leo J. Burdette*
Licensed Embalmer No. *398*
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.