

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016036
STATE FILE NUMBER 3793

FILED APR 18 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If outside, give location) 3701 Bamberger Ave	
3. NAME OF DECEASED (Type or print) First Anna Middle Koberna Last		4. DATE OF DEATH Month April Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 70 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) Mt Olive Illinois		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME William Rozum		13b. MOTHER'S MAIDEN NAME Josephine Micko	14. NAME OF HUSBAND OR WIFE Joseph
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.	17. INFORMANT Address Joseph Koberna 3701 Bamberger Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ apoplexy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 334x			INTERVAL BETWEEN ONSET AND DEATH 8 days
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. INJURY OCCURRED WHILE AT <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 Death occurred at 3/27/58 to 4/2/58 and last saw her alive on 4/2/58		m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Ralph Bergman		22b. ADDRESS 3701 Bamberger Ave	22c. DATE SIGNED 4/3/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/5/58	23c. NAME OF CEMETERY OR CREMATORY Buckroad Cemetery	23d. LOCATION (City, town, or county) (State) Edwardsville Illinois
24. FUNERAL DIRECTOR ADDRESS Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. APR 4 '58	26. REGISTRAR'S SIGNATURE J. Care Smith, M.D. S.P.

(Licensed Embelmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases not art might be laboratory reference

[Faint handwritten signature]

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 *[Signature]*....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *George J. Svoboda Jr.*.....

Licensed Embalmer No. 4899.....

P. O. Address 1926 Allen.....

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.