

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023197
STATE FILE NUMBER

FILED JUN 24 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5902

300
1-57
0

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|---|---------------------------|---|--|--|---|
| 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 | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1 | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 2237 1849 S 9th Street | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Edward Joseph Censky | | | 4. DATE OF DEATH Month Day Year June 5, 1958 | | |
| 5. SEX Male 0 | 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 Dec 20 1890 | | 9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Labor | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) St Louis Mo 0 | | 12. CITIZEN OF WHAT COUNTRY? U S |
| 13a. FATHER'S NAME Fred Censky | | 13b. MOTHER'S MAIDEN NAME Theresa Dvorak | | 14. NAME OF HUSBAND OR WIFE Martha | |
| 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 Martha L Censky 1849 S 9th Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Pancreatitis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> |
| 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) <u>Laennec's Cirrhosis 5811</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> / |
| 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 Month, Day, Year a.m. p.m. | | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from <u>June 3, 1958</u> to <u>June 5, 1958</u> and last saw ^{her} _{him} alive on <u>June 5, 1958</u> Death occurred at <u>8:00</u> P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Daniel J. Mullally, M.D.</u> | | | 22b. ADDRESS <u>1515 Lafayette Ave.</u> | | 22c. DATE SIGNED <u>6/5/58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>6/9/48</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St Paul Churchyard</u> | | 23d. LOCATION (City, town, or county) (State) <u>St Louis County Mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Moydell Funeral Home 1926 Allen</u> | | 25. DATE RECD. BY LOCAL REG. <u>JUN 9 58</u> | | 26. REGISTRAR'S SIGNATURE <u>Carl Smith No 113.</u> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Color, contour, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 J. Svoboda Jr.

Licensed Embalmer No. 4899

P. O. Address 1426 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.