

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041307

STATE FILE NUMBER 11334

19  
FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300  
1-57

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 checked="" 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 SUBST. ST. LOUIS CITY HOSP. #1		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 189 801 S Vandeventer		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last TODOR (Tony) BOLANOVITCH			4. DATE OF DEATH Month Day Year 11 22 58		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct.-5-1892		9. AGE (In years last birthday) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glassworker		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Danic, Yugoslavia 6		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME TRVKO BOLANOVICH		13b. MOTHER'S MAIDEN NAME ANICA KOVACEVICH		14. NAME OF HUSBAND OR WIFE None	
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. 495-22-5680		17. INFORMANT Address Mrs. Josephine Bolanovich 2701 Hickory	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple hepatic duct stones</i>					INTERVAL BETWEEN ONSET AND DEATH <i>week</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>584X</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Subdiaphragmatic abscesses.</i>					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.					
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 <u>11/3/58</u> to <u>11/22/58</u> and last saw <sup>her</sup> him alive on <u>11/22/58</u> Death occurred at <u>4:55</u> <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Jean A. Chapman, M.D.</i>			22b. ADDRESS 1515 LAFAYETTE		22c. DATE SIGNED 11-24-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11/25/1958	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope		23d. LOCATION (City, town, or county) (State) Lemay Mo.
24. FUNERAL DIRECTOR E. J. SCHNIGER		ADDRESS 3125 LAFAYETTE		25. DATE RECD. BY LOCAL REG. NOV 25 '58	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>

All diseases in Part I must be causally related.

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 *Thomas R. Jenewick*

Licensed Embalmer No. *3783*

P. O. Address *3125 Lafayette*

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.