Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041819
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11415

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 01 2140 VICTOR ST — Length of stay in 1b: 239

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 2140 VICTOR — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: SOPHIA Middle: Last: KUCHNO

4. DATE OF DEATH Month: Nov Day: 25 Year: 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: AUG 1 1912

9. AGE (In years last birthday): 46 — 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): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (City and state or country): MISSOURI

12. CITIZEN OF WHAT COUNTRY? U-S-A

13a. FATHER'S NAME: ANDREW REPA

13b. MOTHER'S MAIDEN NAME: TATSIE MAKARA

14. NAME OF HUSBAND OR ~~WIFE~~: STEPHEN KUCHNO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: STEPHEN KUCHNO Address: 2140 VICTOR

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADENOCARCINOMA OF RECTUM WITH WIDESPREAD METASTASIS — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 154X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 AUG 1957 to NOV 1958 and last saw her/him alive on NOV 25, 1958
Death occurred at 11 30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): James J. Leahy MD
22b. ADDRESS: 16 Hampton Village Plaza
22c. DATE SIGNED: 11/26/58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: NOV 28 1958
23c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEM
23d. LOCATION (City, town, or county): ST. LOUIS (State): MO

24. FUNERAL DIRECTOR: Thomas Kutis **ADDRESS:** 2906 Gravois
25. DATE RECD. BY LOCAL REG.: NOV 26 '58
26. REGISTRAR'S SIGNATURE: J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Somer C Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Havana

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.