Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003013
STATE FILE NUMBER

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 977

FILED FEB 10 1959

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St Louis — Inside Limits: Yes # No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 1827 Dolman Str — Length of stay in Ib: 5yrs

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 # No ☐
d. STREET ADDRESS (If outside, give location): 2239 1827 Dolman Street — Reside on Farm: Yes ☐ No #

3. NAME OF DECEASED (Type or print): First: Jaroslav — Middle: — Last: Hajek

4. DATE OF DEATH: Month: Jan — Day: 26 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED # NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 28 1880

9. AGE (Last birthday): 78 — 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): Maintenance

10b. KIND OF BUSINESS OR INDUSTRY: Park Dept

11. BIRTHPLACE (City and state or country): Czechoslovakia 6

12. CITIZEN OF WHAT COUNTRY?: U S

13a. FATHER'S NAME: John Hajek

13b. MOTHER'S MAIDEN NAME: Magdalen Hanzlika

14. NAME OF HUSBAND OR WIFE: Marie

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.: 489-18-8528

17. INFORMANT: Jerry Hajek — Address: 3113 Wyoming Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c): 422.2
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 ☒

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 Jan 26-59 to Jan 26-59 and last saw him alive on 1-26-59
Death occurred at 1-26-59 at 1:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John D Gerl M.D.

22b. ADDRESS: 3739 Bacon

22c. DATE SIGNED: 1-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1/29/59

23c. NAME OF CEMETERY OR CREMATORY: New Picker Cemetery

23d. LOCATION (City, town, or county) (State): St Louis Missouri

24. FUNERAL DIRECTOR — ADDRESS: Moydell Funeral HOme 1926 Allen

25. DATE RECD. BY LOCAL REG.: JAN 28 '59

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.
MDB

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 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.