

FILED MAR 27 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010685  
STATE FILE NUMBER  
2679

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ 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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DOA City Hospital</b>		Length of stay in lb <b>47 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>6554 Murdoch</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle Last <b>BARANOVIC</b>	4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1959</b>
---	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1911</b>	9. AGE (In years last birthday) <b>47 yrs.</b>	10. FUNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
-----------------------	----------------------------------	---	---	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner-operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	---	--	--

13a. FATHER'S NAME <b>Thomas Baranovic, Sr.</b>	13b. MOTHER'S MAIDEN NAME <b>Eva Cibulka</b>	14. NAME OF HUSBAND OR WIFE <b>Anna Urban Baranovic</b>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>494-01-2818</b>	17. INFORMANT Address <b>Mrs. Anna Baranovic, 6554 Murdoch Avenue</b>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction - recurrent</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <b>H2O.i</b>	
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>

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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--

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 <b>Jan. 23 1959 to 3/13/59</b> and last saw him alive on <b>2/15/59</b> <b>4:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>Frank Baranovic M.D.</b>	22b. ADDRESS <b>5203 Chesapeake</b>	22c. DATE SIGNED <b>3-14-59</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>March 17, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Our Redeemer Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri.</b>
---	------------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <b>Beiderwieden F.H.Inc. 1936 St. Louis</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 17 '59</b>	26. REGISTRAR'S SIGNATURE <b>Karl Smith, M.D.</b>
---	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms when deceased. All diseases in Part I must be causally related.

1-3 T 45  
1-3

**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 .....

Licensed Embalmer No. ....

P. O. Address .....

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.