

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011435
STATE FILE NUMBER
Registration No. 3144

FILED APR 10 1959 Registration District No. Primary Registration District No. Registrar No. 3144

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		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEACONESS HOSPITAL		d. STREET ADDRESS (If outside, give location) 4664 LOUISIANA	
3. NAME OF DECEASED (Type or print) First Middle Last FEODORA SUKALO		4. DATE OF DEATH Month Day Year MARCH 27 1959	
5. SEX FEMALE	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 MAY 31 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 71 Months Days Hours Min.
11. BIRTHPLACE (City and state or country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U - S - A	
13a. FATHER'S NAME TARAS PUZEKO		13b. MOTHER'S MAIDEN NAME KATHERINE ZUBARIK	14. NAME OF HUSBAND OR WIFE MIKE SUKALO
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. NONE	17. INFORMANT MIKE SUKALO 4664 LOUISIANA
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension Cardiac embolism 3 weeks DUE TO (b) Chronic glomerular Nephrit; 3 weeks DUE TO (c) Cardiovascular - Renal disease 12 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 442X			INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from 10-3-58 to 3-27-59 and last saw her alive on 3-27-59 Death occurred at 3-27-59 1:20 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. S. Smith, M.D.		22b. ADDRESS 5203 Chippewa	
22c. DATE SIGNED 3-28-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE MAR 30 1959	
23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois		25. DATE RECD. BY LOCAL REG. MAR 30 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

2414 1-1562

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 James C Hill
Licensed Embalmer No. _____
P. O. Address 2906 Dora

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.