

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015772

STATE FILE NUMBER

Registrar's **2 2799**

Health,
& Welfare
Public
Service

FILED MAY 1 1959

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hosp.</u> Length of stay in 1b _____		d. STREET ADDRESS (If outside, give location) <u>2031 Allen Av.</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Mary Srnka.</u>			4. DATE OF DEATH Month Day Year <u>Mar. 17 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4 1884</u>	9. AGE (In years last birthday) <u>74</u>	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, or in if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Charles Forst</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Broz</u>		14. NAME OF HUSBAND OR WIFE <u>Otto Srnka 2031 Allen.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>489-14-1108A</u>		17. INFORMANT Address <u>Otto Srnka 2031 Allen Av.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> <u>abscess in left hip area</u> Conditions, if any, which caused (a) to occur (b) (c) <u>due to abscess in left hip area</u> Tying the knot <u>1/19/59</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>693.4</u>			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.) <u>None</u>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>None</u>			

20d. INJURY OCCURRED WHILE AT WORK <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>1945</u> to <u>March 11, 1959</u> and last saw her/him alive on <u>March 11, 1959</u> Death occurred at <u>9:30 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>S. A. Majumdar</u>	22b. ADDRESS <u>50 S. Del. Hotel Bldg</u>	22c. DATE SIGNED <u>3-19-59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S. S. Peter + Paul Cem</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>
24. FUNERAL DIRECTOR <u>Walt Bro. L + W. Co.</u>	ADDRESS <u>2929 S. Jefferson</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 19 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u> <u>mdb</u>

(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

MEDICAL CERTIFICATION

300
1-57
7
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DR Maizus

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 *Herbert J. Gou Jr.*

Licensed Embalmer No. *4800*

P. O. Address *Hickwood 22, Mo*

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.