

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016184
STATE FILE NUMBER

W. Fitzgerald
FRED MAY 15 1958
1530 Hwy
B-26

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1322

300
-57

1. PLACE OF DEATH a. COUNTY St. Louis		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 Richmond Heights		c. CITY OR TOWN Bull Run	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp.		d. STREET ADDRESS (If outside, give location) MONS.	

3. NAME OF DECEASED (Type or print) First Middle Last JULIAN ROKASKY			4. DATE OF DEATH Month Day Year May 9, 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1876	9. AGE (in years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Budepest, Hungry	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME George Sabo	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Julius Rokasky
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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 Address Mrs. VanMartin, Flat River, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 4 days
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 DUE TO (b) **Hypertensive Vascular disease**
 DUE TO (c) **General Arteriosclerosis**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Diabetes Mellitus **33ix**

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.)
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	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
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21. I attended the deceased from FEB. 1959 to 5-9-59 and last saw her ^{her} alive on 5-8-59 Death occurred at 3:55 AM m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) William T. Fitzgerald M.D.	22b. ADDRESS 3915 WATSON Rd.	22c. DATE SIGNED 5-14-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-10-1959	23c. NAME OF CEMETERY OR CREMATORY Catholic Cem.	23d. LOCATION (City, town, or county) (State) Farmington, Mo.
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24. FUNERAL DIRECTOR ADDRESS Caldwell, Flatriver, Mo.	25. DATE RECD. BY LOCAL REG. 5-13-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Clarence M. Bille*

Licensed Embalmer No. *4375*
P. O. Address *St. Louis, 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.