

pt. Health,
, & Welfare
S. Public
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023038
STATE FILE NUMBER

FILED JUL 13 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **6027**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros.		d. STREET ADDRESS (If outside, give location) 3113a Wyoming	
Length of stay in lb 7 wks		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last Albert J. Jenicek			4. DATE OF DEATH Month Day Year June 23, 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1887
9. AGE (In years last birthday) 72		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) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailoring	11. BIRTHPLACE (City and state or country) Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME ? Jenicek	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Anna Jenicek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 489-09-5636	17. INFORMANT Address Marle Hajek 3113 Wyoming
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 anoxia			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerotic cerebro-cardio-vascular disease			over 5 years
DUE TO (c)			
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? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			334X
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. 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 13 June 1959 to 23 June 1959 and last saw him alive on 23 June 1959 Death occurred at 2:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert S. Nye, M.D.		22b. ADDRESS 3201 Arsenal St., St. Louis Mo.	22c. DATE SIGNED 25 June 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/26/59	23c. NAME OF CEMETERY OR CREMATORY New Picker Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Mo
24. FUNERAL DIRECTOR ADDRESS Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. JUN 25 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

M D 15

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 *Halley J. Gailler Jr*
Licensed Embalmer No. *9950*
P. O. Address *St Louis*

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.