

pt. Health,
, & Welfare
S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23061

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No.

Primary Registration District No.

Registrar's No. 5634

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Mo.</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4225 NEOSHO</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>4225 NEOSHO</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY A. KALAFATICH</i>			4. DATE OF DEATH Month Day Year <i>June 11 1959</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 26 1886</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>KITCHEN HELPER</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>YUGO-SLAVIA</i>
13a. FATHER'S NAME <i>JOHN DERKOS</i>		13b. MOTHER'S MAIDEN NAME <i>MARY VUKELIC</i>	14. NAME OF HUSBAND OR WIFE <i>JOHN KALAFATICH</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or in town) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT Address <i>JOHN KALAFATICH 4225 NEOSHO</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Heart Disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>443x</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6/15/59</i>
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 WORK <input type="checkbox"/> NOT WHILE 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 <i>May 15, 1959</i> to <i>June 11, 1959</i> and last saw her ^{her} _{him} alive on <i>May 19, 1959</i> Death occurred at <i>3110</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Bernard T. K... M.D.</i>		(Degree or title)	22b. ADDRESS <i>4268 Oak Street, N. Kansas, Mo.</i>
22c. DATE SIGNED <i>6/12/59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<i>BURIAL</i>	<i>JUNE 13 1959</i>	<i>S.S. PETER & PAUL</i>	<i>ST. LOUIS Mo</i>
24. FUNERAL DIRECTOR <i>Thomas Kutea 2906 Grassie</i>		25. DATE RECD. BY LOCAL REG. <i>JUN 12 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

209B

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 E. Leus Province

Licensed Embalmer No. 3403
P. O. Address Jennings

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.