

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023441
STATE FILE NUMBER

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar **2-5753**

S. 300
v. 1-57
4

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, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3625 Michigan Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) JULIUS SUBRACKO			4. DATE OF DEATH Month Day Year JUNE 15, 1959		
5. SEX Male	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 Dec. 28, 1893	9. AGE (In years last birthday) 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assist. Foreman		10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.		11. BIRTHPLACE (City and state or country) Romania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME ?		13b. MOTHER'S MAIDEN NAME ?		14. NAME OF HUSBAND OR WIFE Sofia Subrackoo	
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. 489-03-6964A		17. INFORMANT Address Theresa Burghardt 3625 Michigan Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) BILATERAL MIDDLE CEREBRAL ARTERY THROMBOSIS.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332x					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. 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 5/29/59 to 6/15/59 and last saw ^{her} him alive on 6/15/59 Death occurred at 10: P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Of doctor or title) Wm B. Johnson M.D.			22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 6/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/18/59	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR CHULICK UND. CO. 1722 S. Jefferson		ADDRESS		25. DATE RECD. BY LOCAL REG. JUN 17 '59	26. REGISTRAR'S SIGNATURE Roan Smith, M.D. <i>m8B</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.

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.

V E Morris

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No. *3360*

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.