

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 30 1959

2 6682

59-026837

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Length of stay in 1b		c. CITY OR TOWN St Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4006 McDonald			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4006 McDonald			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle A Last KESTRANEK			4. DATE OF DEATH Month July Day 16 Year 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 8-4-1895	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asbestos Worker		10b. KIND OF BUSINESS OR INDUSTRY Stooey Co		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Joseph Kestranek			13b. MOTHER'S MAIDEN NAME Johanna Vleck		14. NAME OF HUSBAND OR WIFE Isabel Kestranek		
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. 489-03-2340	17. INFORMANT Address Isabel Kestranek 4006 McDonald				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Carcinoma of Gastrointestinal Tract - site unknown DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH ABOUT 1 YR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.) None					
20c. TIME OF INJURY Hour _____ p.m. Month, Day, Year _____							
20d. INJURY 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 Sept 1958 to July 1959 and last saw ^{him} alive on July 10, 1959 Death occurred at 520 A on the date stated above, and to the best of my knowledge from the causes stated							
22a. SIGNATURE (Name or title) John Charles Doulek Jr MD				22b. ADDRESS 2767 Gravois			22c. DATE SIGNED 7-16-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 20 1959	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem		23d. LOCATION (City, town, or county) St Louis Co		(State) Mo	
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois			25. DATE RECD. BY LOCAL REG. JUL 17 '59	26. REGISTRAR'S SIGNATURE Karl Smith, M.D. <i>a. e. Th.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gra

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.