

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027693

FILED VS AUG 17 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2134 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St Louis</b>	a. STATE <b>Missouri</b>		b. COUNTY <b>ST LOUIS</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Affton 23</b>	Length of stay in 1b <b>1yr</b>	c. CITY OR TOWN <b>Affton 23</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>8350 Maylor Dr</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8350 Maylor Dr</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <b>Helan</b>	Middle <b>Rose</b>	Last <b>Karmi</b>	Month <b>Aug</b>	Day <b>7</b>
			Year <b>1959</b>	

5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/17/05</b>	9. AGE (last birthday) <b>54</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (City and state or country) <b>Jugoslavia</b>	12. CITIZEN OF WHAT COUNTRY <b>U S</b>
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13a. FATHER'S NAME <b>Joseph Buneta</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Mike</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT <b>Mike Karmi</b>	Address <b>8350 Maylor Dr Affton</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease</b>	DUE TO (b)	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 **Mar 10, 1959** to **Aug 7, 1959** and last saw her alive on **July 23, 1959**  
Death occurred at **4:00 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <b>Demetrius P. Sullivan M.D.</b>	22b. ADDRESS <b>4161 Lindell</b>	22c. DATE SIGNED <b>8-7-59</b>
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23a. BURIAL OR CREMATION <b>Removal</b>	23b. DATE <b>8/10/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St Louis County Mo</b>
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24. FUNERAL DIRECTOR <b>Moydell Funeral Home</b>	ADDRESS <b>1926 Allen</b>	25. DATE RECD. BY LOCAL REG. <b>8-8-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, MD</b>
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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

*Hedley T. J. J. J. J.*

Licensed Embalmer No.

*14950*

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.