

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7492** STATE FILE NUMBER

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, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. Louis City Hosp.		d. STREET ADDRESS (If outside, give location) 1423 E Buchanan	

3. NAME OF DECEASED (Type or print) First Lillian Middle (PRAZAR) Last PRAZAK			4. DATE OF DEATH Month August Day 12 Year 1959		
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5. SEX F	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 1-1-1889	9. AGE (last birthday) 72	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) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) New York, NY	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Frank Shannon	13b. MOTHER'S MAIDEN NAME Barbara Hamberger	14. NAME OF HUSBAND OR WIFE Deceased
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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) No	16. SOCIAL SECURITY NO. 320-22-2423	17. INFORMANT Address Floyd McKwan - 1423 E Buchanan
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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 4 days
IMMEDIATE CAUSE (a) Myocardial Infarction		
DUE TO (b) Atherosclerotic Coronary Thrombosis		
DUE TO (c) 4201		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus	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 _____

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 **8/8/1959** to **8/12/1959** and last saw her ^{her} _{him} alive on **8/8/1959**
 Death occurred at **3:00** A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul W. Spieck M.D.	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 8/12/1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 14, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo
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24. FUNERAL DIRECTOR ADDRESS Mr Koch & Son - 3516 E 14th	25. DATE RECD. BY LOCAL REG. AUG 12 '59	REGISTRAR'S SIGNATURE Paul Smith, M.D.
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2086

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 W E Morris

Licensed Embalmer No. 3360

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.