

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030859

INDEXED

VS AUG 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **8 7315** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)	
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. ANTHONY Hosp.		d. STREET ADDRESS (if outside, give location) 411 FASSEN	

3. NAME OF DECEASED (Type or print) First MARY Middle J. Last VALENTA			4. DATE OF DEATH Month AUG. Day 4 Year 1959			
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AUG. 1 1889	9. AGE (last birthday) 70	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) WIDOW		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) MO		12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME JOHN VORACEK		13b. MOTHER'S MAIDEN NAME JOSEPHINE SATEK		14. NAME OF HUSBAND OR WIFE WM VALENTA	
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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)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARY L. ULRICH VIENNA	
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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 1 1/2 Days ? ?
IMMEDIATE CAUSE (a) Uterine Hemorrhage			
DUE TO (b) Carcinoma of uterus			
DUE TO (c) Uterine Bleeds & Embryonics			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 174X			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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ s.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 **7/20/59** to **8/4/59** and last saw her **8/4/59** alive on **8/4/59**
Death occurred at **1:30** **P** m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE Walter J. Sumner	(Degree or title)	22b. ADDRESS 4617 Duhon Ave.	22c. DATE SIGNED 8/5/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUG. 7 1959	23c. NAME OF CEMETERY OR CREMATORY S-S. PETER & PAUL	23d. LOCATION (City, town, or county) ST. LOUIS MO
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24. FUNERAL DIRECTOR Thomas Kutas 2906 Gravois	ADDRESS	25. DATE RECD. BY LOCAL REG. AUG 6 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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 Eleanora Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grove

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.