

FEDERAL BUREAU OF INVESTIGATION  
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033713

FILED VS SEP 21 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2-8304**

MEMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>	Length of stay in 1b <b>10 yrs</b>	c. CITY OR TOWN <b>St Louis</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>5922 Clifton Ave</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5922 Clifton Ave</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Aloisia</b> Middle <b>Aloisie</b> Last <b>Cukr</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/4/84</b>	9. AGE (last birthday) <b>75</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>
13a. FATHER'S NAME <b>John Shrbeni</b>		13b. MOTHER'S MAIDEN NAME <b>Rosalia ?</b>		14. NAME OF HUSBAND OR WIFE <b>Charles (Deceased)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>William Cukr 5922 Clifton Ave</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH ACUTE CARDIAC FAILURE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 YRS 1 HR.</b>
DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>			
DUE TO (c) <b>420.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ANTERO-SEPTAL INFARCTION OLD.</b>			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 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 _____ 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	
21. I attended the deceased from <b>MAY 1950</b> to <b>SEPT 6 1959</b> and last saw her <sup>her</sup> alive on <b>SEPT 6 1959</b> Death occurred at <b>7:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <b>Henry T Cooper M.D.</b>		22b. ADDRESS <b>818 Olive St.</b>		22c. DATE SIGNED <b>9/7/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/9/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Picker Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St Louis Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Moydell Funeral Home 1926 Allen</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 9'59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith. M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Halley R. Jaeller Jr  
Licensed Embalmer No. 4950

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.