OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 30 1959

210748 59-041721

STATE FILE NUMBER

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

AMENDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Anthony Hospital

Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY

c. CITY OR TOWN: St. Louis

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 4020a Hydraulic Ave.

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First ROSE Middle Last CSIACSEK

4. DATE OF DEATH: Month Nov. Day 20 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 5-29-1882

9. AGE (last birthday): 77

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): Housework

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (City and state or country): Yugoslavia

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: ~~Unknown~~

13b. MOTHER'S MAIDEN NAME: Rose ~~Eckstein~~

14. NAME OF HUSBAND OR WIFE: Late Joseph Csiacsek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.

17. INFORMANT: Address: Rose Hummel 4145 Fabian Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Cardiovascular disease

DUE TO (c): Arteriosclerosis 331X

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES X NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Jan. 1955, to Nov. 19th 1959 and last saw her/him alive on Nov. 19th 1959

Death occurred at 3:05 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Theodore A. Siebert MD

22b. ADDRESS: 2000 S Broadway

22c. DATE SIGNED: 11/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Nov. 23, 1959

23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Kriegshauser

ADDRESS: 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG.: NOV 21 1959

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Funeral Director DOCUMENT

Rose Link Rose Eckstein 13b 12/7/59

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4533

P. O. Address _____

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