

**MINNESOTA DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS JAN - 8 1960**

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Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **211900** STATE FILE NUMBER \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b _____	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital DOA</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3339 Michigan</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Novatny aka Joseph Novotny</b>			4. DATE OF DEATH Month Day Year <b>December 21 1959</b>				
5. SEX <b>male</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>5/1/1870</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>brewery worker</b>		11. BIRTHPLACE (City and state or country) <b>Austria Hungary</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Joseph Novatny</b>			13b. MOTHER'S MAIDEN NAME <b>not known</b>		14. NAME OF HUSBAND OR WIFE <b>Anastasia</b>		
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>489-18-9134A</b>		17. INFORMANT <b>Eva Novatny</b>			Address <b>3339 Michigan</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) **Second and third degree burns of 90% of Body.**  
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  
 DUE TO (b) \_\_\_\_\_  
 DUE TO (c) \_\_\_\_\_  
 INTERVAL BETWEEN ONSET AND DEATH  
**9/16.0 16**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**Suffered when fell in his room at home Dec 21st 1959.**  
**Cause and manner of death could not be determined**

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 cert) <b>fell in his room at home Dec 21st 1959.</b>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <b>12 21 59</b>	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.) <b>home</b>	20f. CITY, TOWN, OR LOCATION <b>St Louis Mo</b>	COUNTY STATE	

21. I attended the deceased from \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Patricia Taylor Casner</b> (Degree or title)	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>12.23.59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>12/24/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>
24. FUNERAL DIRECTOR <b>John L Ziegenhein &amp; Sons</b> ADDRESS <b>7027 Gravois</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>

25. DATE RECD. BY LOCAL REG. <b>DEC 23 1959</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith. M.D.</b>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

*m J.B.*

**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

*C. P. Kidwell*

Licensed Embalmer No. 3877

P. O. Address 7027 Grand

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.