

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 5 1960

-60-004192

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 754** STATE FILE NUMBER

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| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>               |  | Length of stay in 1b<br><b>3 mo. 3 wks.</b>  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   | d. STREET ADDRESS <b>4252 Connecticut</b> (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                      |        |                        |                                    |                   |                  |                   |
|--|----------------------|--------|------------------------|------------------------------------|-------------------|------------------|-------------------|
| 3. NAME OF DECEASED (Type or print)<br><b>John Vitacek</b> | First<br><b>John</b> | Middle | Last<br><b>Vitacek</b> | 4. DATE OF DEATH<br><b>1-21-60</b> | Month<br><b>1</b> | Day<br><b>21</b> | Year<br><b>60</b> |
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|                       |                                  |   |                                    |                                     |                                |                              |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widow <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/29/84</b> | 9. AGE (last birthday)<br><b>75</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>unknown</b> | 11. BIRTHPLACE (City and state or country)<br><b>Bohemia</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
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| 13a. FATHER'S NAME<br><b>John Vitacek</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Clara Krucek</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Mamie Stuckel Vitacek</b> |
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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)<br><b>no</b> | 16. SOCIAL SECURITY NO.<br><b>unknown</b> | 17. INFORMANT<br><b>Mrs. Helen Lusch-3532 Bamberger</b> | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |  | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Acute Bacterial Congestion Lungs</b>   |  | <b>2 days</b>  |
| DUE TO (b) <b>Arteriosclerotic Heart Disease</b>  |  | <b>4 mo.</b>   |
| DUE TO (c) <b>Generalized Arteriosclerosis</b>  |  | <b>4 mo.</b>   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| <b>Closed Fracture Left Femur</b>   |  |  |

|   |  |   |
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| 19. WAS AUTOPSY PERFORMED?<br>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 item 18.)<br><b>Unknown cause. PT. was found</b> |
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|---|-------------------|---|
| 20c. TIME OF INJURY<br><b>Unk. (P.M.)</b> | Hour<br><b>10</b> | Month, Day, Year<br><b>10/17/59 on floor under bed.</b> |
|---|-------------------|---|

|   |   |  |                      |       |
|---|---|--|----------------------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Chronic Hospital</b> | 20f. CITY, TOWN, OR LOCATION<br><b>St. Louis</b> | COUNTY<br><b>Mo.</b> | STATE |
|---|---|--|----------------------|-------|

|  |   |
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| 21. I attended the deceased from <b>9-29-59</b> to <b>1-21-60</b> and last saw her alive on <b>1-21-60</b> | Death occurred at <b>2:50 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |
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|  |                   |                                     |                                    |
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| 22a. SIGNATURE<br><b>John W. Beckham, M.D.</b> | (Degree or title) | 22b. ADDRESS<br><b>5800 Arsenal</b> | 22c. DATE SIGNED<br><b>1/21/60</b> |
|--|-------------------|-------------------------------------|------------------------------------|

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>Jan. 25, 1960</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Picker Cemetery</b> | 23d. LOCATION (City, town, or county)<br><b>St. Louis, Missouri</b> |
|---|-----------------------------------|--|---|

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|--|---------|--|--|
| 24. FUNERAL DIRECTOR<br><b>WACKER-HELDERLE-3634 Gravois Ave.</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 22 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith, M.D.</b> |
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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 *Deloit J. Krupin*

Licensed Embalmer No. 3497

P. O. Address St. Louis

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