

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009387

FILED VS MAR 3 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 430

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST Louis County</u>		Length of stay in 1b <u>3 Mnths</u>		c. CITY OR TOWN <u>Richmond Heights</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mt Saint Rose Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6420 Clayton Rd</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Jurcic</u> Last <u>Jurcic</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5/27/78</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (City and state or country) <u>Jugoslavia</u>		12. CITIZEN OF WHAT COUNTRY <u>U S</u>	
13a. FATHER'S NAME <u>Anton Jurcic</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Sadovac</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Mary Hahn</u> Address <u>7036 Dale Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAR PULMONALE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <u>Emphysema Obstructive</u> <u>10 years</u>	
DUE TO (c) <u>Bronchial Asthma</u> <u>? years</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diverticulosis. Hiatus Hernia</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 <u> </u> a.m. <u> </u> p.m.		Month, Day, Year <u> </u>						
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 <u>1950</u> to <u>Feb 9 1960</u> and last saw <u>her</u> him alive on <u>Feb 2, 1960</u> Death occurred at <u>4:10 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Robert C Sweet M.D</u>				22b. ADDRESS <u>508 N. Grand</u>		22c. DATE SIGNED <u>2-9-60</u>		
23a. BURIAL REGISTRATION <u>BURIAL</u>		23b. DATE <u>2/12/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis County Mo.</u>			
24. FUNERAL DIRECTOR <u>Moydell Funeral Home</u> ADDRESS <u>1926 Allen</u>				25. DATE RECD. BY LOCAL REG. <u>2-10-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

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

Shelley R. Kaeller

Licensed Embalmer No. 9950

P. O. Address St. Louis

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