

60-013739

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 5 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 930

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>AFFTON</u>		Length of stay in 1b <u>None</u>	c. CITY OR TOWN <u>ST. LOUIS</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>Mihler NURSING HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3322 PENNSYLVANIA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>F.</u> Last <u>KADLEC</u>			4. DATE OF DEATH Month <u>MAR</u> Day <u>17</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1872</u>	9. AGE (last birthday) <u>88</u>	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) <u>RETIRED TAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>BOHEMIA</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOSEPH KADLEC</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MARY KADLEC (Dec'd)</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.		17. INFORMANT Address <u>CHARLES KADLEC 5425 CHRISTY</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (Left side)</u>			<u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Arteriosclerosis</u>		<u>1 yr.</u>
	DUE TO (c) <u>Chronic Nephritis</u>		<u>1 yr.</u>
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. <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 a.m. p.m.	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 March 2nd 1960 to March 17th '60 and last saw her/him alive on March 17th '60  
 Death occurred at 10<sup>12</sup> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. H. Walters M.D.</u>	22b. ADDRESS <u>3608 South Grand Blvd.,</u>	22c. DATE SIGNED <u>3/18/60</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAR 19, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION Cem ST. LOUIS Co. Mo.</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>3-19-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

Handwritten notes on the right margin, including the word "Handwritten" and some illegible scribbles.

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grav

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