

**FEDERAL BUREAU OF INVESTIGATION**  
**U.S. DEPARTMENT OF JUSTICE**  
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**U.S. DEPARTMENT OF JUSTICE**

**URI DIVISION. OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-017735**

**FILED VS MAY 12 1960**

STATE FILE NUMBER

Registration District No. <b>317</b>		Primary Registration District No. <b>547</b>		Registrar's No. <b>1333</b>	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>ST. LOUIS</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RICHMOND HEIGHTS</b> Length of stay in 1b c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. MARYS HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY c. CITY OR TOWN <b>ST. LOUIS</b> d. STREET ADDRESS (If outside, give location) <b>3650<sup>th</sup> WYOMING</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARIE</b> Middle <b>MATEJA</b> Last <b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>20</b> Year <b>1960</b>			<b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>JAN 28 1913</b> <b>9. AGE (last birthday)</b> <b>47</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CLEANER &amp; DYER</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>LUNGSTRAS</b> <b>11. BIRTHPLACE</b> (City and state or country) <b>PENNSYLVANIA</b> <b>12. CITIZEN OF WHAT COUNTRY</b> <b>U-S-A</b>		
<b>13a. FATHER'S NAME</b> <b>MICHAEL BUSONIC</b> <b>13b. MOTHER'S MAIDEN NAME</b> <b>14. NAME OF HUSBAND OR WIFE</b> <b>JOSEPH MATEJA</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>JOSEPH MATEJA 3650<sup>th</sup> WYOMING</b> Address		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma - cervix</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ <b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____		<b>21. I attended the deceased from</b> <b>1959</b> to <b>1960</b> <b>death</b> and last saw her him alive on <b>4/20/60</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.	
<b>22a. SIGNATURE</b> <b>(Degree or title)</b> <b>22b. ADDRESS</b> <b>22c. DATE SIGNED</b> <b>Thomas R. Rutka M.D.</b> <b>16 Thayer Village Plaza</b> <b>4/20/60</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>23b. DATE</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>23d. LOCATION (City, town, or county)</b> (State) <b>REMOVAL APR 23 1960</b> <b>ST. PETER + PAUL</b> <b>ST. LOUIS</b> <b>MO</b>		<b>24. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>25. DATE RECD. BY LOCAL REG.</b> <b>26. REGISTRAR'S SIGNATURE</b> <b>Thomas R. Rutka 2906 Gravois</b> <b>4-25-60</b> <b>John C. Wiggley M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1-4 1957

**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 Eleus Province

Licensed Embalmer No. 3403

P. O. Address 7906 River

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.