

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024684

FILED VS JUL 15 1960

318

Primary Registration District No. 1003

Registrar's No. 6497

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Wd. Hosp.		d. STREET ADDRESS (If outside, give location) 4993 Blow	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Anna Kulifay			4. DATE OF DEATH Month Day Year June 23, 1960			
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5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1885	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY housewife	11. BIRTHPLACE (City and state or country) Czechoslovakia	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Michael Ingeli	13b. MOTHER'S MAIDEN NAME Mary Maais	14. NAME OF HUSBAND OR WIFE Steve Kulifay
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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) no	16. SOCIAL SECURITY NO. unk	17. INFORMANT Steve Kulifay	Address 4993 Blow
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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>Cystic Adenoma Rt Ovary with Metastases</u> DUE TO (b) _____ DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1750		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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from <u>June 1942</u> to <u>June 23, 1960</u> and last saw her/him alive on <u>June 23, 1960</u> Death occurred at <u>125 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22. SIGNATURE (Degree or title) <u>Joseph E. Carney M.D.</u>	22b. ADDRESS <u>906 Olive</u>	22c. DATE SIGNED <u>6-25-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6-27-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Concordia Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>Southern Funeral Home</u> 6322 S. Grand, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. <u>JUN 27 1960</u>	26. REGISTRAR'S SIGNATURE <u>Karl Smith M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr J. Carney

Fusco Bldg

~~J. T. J.~~

Dr. Carney is official to sign above

**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

David Van Fossan

Licensed Embalmer No. 4243

P. O. Address St Louis Mo

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.