

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028259

FILED VS. JUL 22 1960

STATE FILE NUMBER

Registration District No. <b>318</b>		Primary Registration District No. <b>1003</b>		Registrar's No. <b>6928</b>		
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>40 Yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>6678 Berthold Ave. (10)</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MRS. ZORKA HERBEZ DODER</b>			4. DATE OF DEATH Month Day Year <b>July 8, 1960</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1892</b>	9. AGE (last birthday) <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Herzegovina, Yugoslavia</b>	12. CITIZEN OF WHAT COUNTRY <b>?</b>	
13a. FATHER'S NAME <b>(unknown) Herbez</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Dusan Vidak Doder</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Gary, Ind.</b> <b>Mrs Wm E Anderson 1720 W 5th Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATO-RENAL FAILURE</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>HEPATITIS DUE TO THIOAZINE</b> DUE TO (c) <b>953X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>DIABETES MELLITUS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>2 WKS.</b>	
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.)			
20c. TIME OF INJURY Hour Month, Day, Year 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 <b>FEB. 21, 1960</b> to <b>July 8, 1960</b> and last saw her <sup>her</sup> alive on <b>July 8, 1960</b> Death occurred at <b>10:45 p.m. July 8, 1960</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Robert Elach M.D.</b> (Degree or title)			22b. ADDRESS <b>35 N Central Ave. (5)</b>		22c. DATE SIGNED <b>7/9/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/11/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Missouri</b>		
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>JUL 11 1960</b>	26. REGISTRAR'S SIGNATURE <b>Head Smith M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Robt. E. Koch  
35 N. Central Ave.  
Pa. 5 9656

**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

*Joseph E. McCallister*

Licensed Embalmer No. 2760

P. O. Address 6175 Rd

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.