# URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

EILED VS AUG 4 1960

60-028695
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7286

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. ANTHONY HOSPITAL — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5450 FINKMAN — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle J Last PECKA
4. DATE OF DEATH: Month JULY Day 18 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: OCT 28 1886
9. AGE (last birthday): 73 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SHOE WORKER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): BOHEMIA
12. CITIZEN OF WHAT COUNTRY: U-S-A
13a. FATHER'S NAME: JOSEPH PECKA
13b. MOTHER'S MAIDEN NAME: ANNA JECEK
14. NAME OF HUSBAND OR WIFE: AGNES PECKA
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.: 492-10-1626
17. INFORMANT: AGNES PECKA Address: 5450 FINKMAN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 20 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Myocardit and Arteriosclerotic — 10 yr.
DUE TO (c): Heart disease 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Anemia of undetermined origin

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 6/20/60, to 7/18/60 and last saw her/him alive on 7/18/60
Death occurred at 6:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Albert M Repetto MD
22b. ADDRESS: 405 University Club Bldg.
22c. DATE SIGNED: 7/21/60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: JULY 22, 1960
23c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS MO.

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: JUL 21 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

2-4 P.M. 3 [illegible]

RM 405

**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 _____ Signed [signature]

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 [illegible]

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