

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-035289**

**FILED VS SEP 29 1960**

160

Registration District No. \_\_\_\_\_ Primary Registration District No. 559 Registrar's No. 118

STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JEFFERSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FESTUS Mo</u> Length of stay in ill. _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MOUNTAIN VIEW Home</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY _____ c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2910 KEOKUK</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MARY</u> Middle <u>BALEK</u> Last _____			<b>4. DATE OF DEATH</b> Month <u>SEPT.</u> Day <u>20</u> Year <u>1960</u>				
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>FEB. 4 1880</u>	<b>9. AGE</b> (last birthday) <u>80</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>BOHEMIA</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>JOSEPH CERVENKA</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>FRANK BALEK</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>FRANK BALEK</u> Address <u>162 FLORALEA ST. LOUIS Mo</u>			
<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) <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 INTERVAL BETWEEN ONSET AND DEATH <u>Worse/Wk</u>							
<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.)			
<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"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE			
<b>21. I attended the deceased from</b> <u>9-14-60</u> to <u>9-21-60</u> and last saw her/him alive on <u>9-20-60</u> Death occurred at <u>9:40 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>B. J. Donnell, M.D.</u>			<b>22b. ADDRESS</b> <u>112 Mississippi Ave. Crystal City Mo.</u>		<b>22c. DATE SIGNED</b> <u>9-22-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE</b> <u>SEPT. 23</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peter &amp; Paul</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>ST. LOUIS Mo</u>		
<b>24. GENERAL DIRECTOR</b> <u>Thomas Dutes 2906 Beavon</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-22-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 29 1960

**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 Eleanor Brown

Licensed Embalmer No. 340

P. O. Address 2916 York

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