IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 14 1960

-60-036434

NDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9672 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b: 4 WEEKS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. ANTHONYS HOSPITAL
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 6205 HOFFMAN
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ADALBERT Middle C. Last NOVAK
4. DATE OF DEATH: Month OCTOBER Day 2 Year 1960
5. SEX: MALE
6. COLOR OR RACE: CAUCASIAN
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9/10/1879
9. AGE (last birthday): 81
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
10b. KIND OF BUSINESS OR INDUSTRY: SHOE WORKER
11. BIRTHPLACE (City and state or country): ST. LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: FRANK NOVAK
13b. MOTHER'S MAIDEN NAME: MARY HURDLICA
14. NAME OF HUSBAND OR WIFE: MARY EMILY NOVAK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 492-01-8618
17. INFORMANT: MRS. MARY EMILY NOVAK, 6205 HOFFMAN Address: ST. LOUIS

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): Arteriosclerotic Heart Disease with acute Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Cerebro-vascular thrombosis
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 7-22-53 to 10-2-60 and last saw him alive on 10-2-60
Death occurred at 8:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Henry T. Cooper M.D.
22b. ADDRESS: 818 Olive St.
22c. DATE SIGNED: 10/4/60
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10/5/1960
23c. NAME OF CEMETERY OR CREMATORY: ST. PETER AND PAUL
23d. LOCATION (City, town, or county) (State): ST. LOUIS, MISSOURI
24. FUNERAL DIRECTOR ADDRESS: HOFFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA STREET ST. LOUIS MISSOURI
25. DATE RECD. BY LOCAL REG.: OCT 5 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

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 Bill C. Branson

Signature of Student Embalmer

Licensed Embalmer No. 4764

P. O. Address St Louis

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.