

FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 26 1960 318 Primary Registration District No. 1003 Registrar's No. 10230 ~~60-039611~~ STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Length of stay in 1b <u>4 MONTHS</u>		c. CITY OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LITTLE FLOWER HOME</u>				d. STREET ADDRESS (If outside, give location) <u>1818 Geyer</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>J.</u> Last <u>CHALUPNY</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>19</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-1874</u>	9. AGE (last birthday) <u>85</u>	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) <u>RETIRED CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HEAVY COFFEE</u>		11. BIRTHPLACE (City and state or country) <u>BOHEMIA</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>JOSEPH CHALUPNY</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA SYKORA</u>		14. NAME OF HUSBAND OR WIFE <u>AGNES CHALUPNY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-01-7514</u>		17. INFORMANT Address <u>AGNES CHALUPNY 1818 Geyer</u>			
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>Acute Cardiac Dilatation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
DUE TO (b) <u>Uræmic Poisoning</u>							<u>2 mos.</u>
DUE TO (c) <u>Chr. Myocarditis</u> <u>422.1</u>							<u>8 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arterio Sclerosis - Senility</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>Stroke</u>					
20c. TIME OF INJURY Hour Month, Day, Year <u>none</u>							
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 <u>Jan. 6 - 1954</u> to <u>Oct 19 - 1960</u> and last saw her alive on <u>October 18 - 1960</u> Death occurred at <u>1:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Frank Laubach M.D.</u>				22b. ADDRESS <u>2767 Garrison</u>		22c. DATE SIGNED <u>10-21-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>OCT 22 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION Cem</u>		23d. LOCATION (City, town, or county) (State) <u>ST. Louis Co. Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kuto 2906 Garrison</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 21 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

after 2-10-1912

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 Eleana Province

Licensed Embalmer No. 3403
P. O. Address 2906 Grov

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.