

NDED

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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>27 days</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>9158 Frederick</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>M</b> Last <b>KOZAK</b>			4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1960</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</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>3/29/1879</b>	9. AGE (last birthday) <b>81 years</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Czechoslovakia</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Joseph Miskuf</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Prischak</b>	14. NAME OF HUSBAND OR WIFE <b>Stefan F. Kozak</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.	17. INFORMANT Address <b>Margaret Kozak - 9158 Frederick</b>
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
IMMEDIATE CAUSE (a)	<b>Cerebral artery, thrombosis of</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Arteriosclerotic Heart Disease</b>	
DUE TO (b)	<b>Diabetes mellitus</b>	<b>6 weeks</b>
DUE TO (c)		<b>1 yr</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>260x</b>		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
--	--	---

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.)
---	---	--

20c. TIME OF INJURY Hour <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Month, Day, Year
--	------------------

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 <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Missouri</b>
--	--	--	----------------------------	--------------------------

21. I attended the deceased from **3-9-67** to **11-13-66** and last saw her <sup>her</sup> <sub>him</sub> alive on **11-10-66**.  
 Death occurred at **2:28 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS <b>634 N. Grand</b>	22c. DATE SIGNED <b>11-14-66</b>
--------------------------------------	-------------------	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>Nov. 17, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Benld Cemetery</b>	23d. LOCATION (City, town, or county) <b>Benld Illinois</b>
---	-----------------------------------	---	--

24. FUNERAL DIRECTOR <b>BUCHHEIZ MORTUARY-5967 W. Florissant Ave</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 14 1960</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

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 \_\_\_\_\_

Signature of Student Embalmer

Signed *William S. B...*

Licensed Embalmer No. 4551

P. O. Address *St. Louis*

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