RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-044689

FILED VS DEC 1 1960

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3385 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY: ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ~~St Louis~~ VALLEY PK. Length of stay in 1b: WKS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Home Valley Park Nursing 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): 1037 Geyer Ave Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Elizabeth Middle: Last: Kalna
4. DATE OF DEATH Month: Nov Day: 19 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 11/20/80
9. AGE (last birthday): 79 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (City and state or country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY: U S
13a. FATHER'S NAME: Joseph Kanuch
13b. MOTHER'S MAIDEN NAME: Mary Michalex
14. NAME OF HUSBAND OR WIFE: Michael KALNA
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.: —
17. INFORMANT: Helen Burke Address: 1839A Dolman Street

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) Gastrointestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 24 HRS
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. ☐ 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 9-19-60, to 11-19-60 and last saw her/him alive on 11-17-60
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John W Doake (Degree or title) M.D
22b. ADDRESS 740 S. 4th St. Louis
22c. DATE SIGNED 11-21-60

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 11/22/60
23c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery
23d. LOCATION (City, town, or county) (State) St Louis Missouri

24. FUNERAL DIRECTOR Moydell Funeral Home ADDRESS 1926 Allen
25. DATE RECD. BY LOCAL REG. 11-21-60
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Hudley F. Faeller Jr

Signature of Student Embalmer

Licensed Embalmer No. 4950

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.