

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CITY HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>2852 WYOMING</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>STEPHEN YANOSCHEK</b>			4. DATE OF DEATH Month Day Year <b>DEC. 15 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 9, 1879</b>	9. AGE (last birthday) <b>81</b>	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) <b>RETIRED BRICKLAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>AUSTRIA HUNGARY U-S-A</b>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <b>KARL YANOSCHEK</b>		13b. MOTHER'S MAIDEN NAME <b>ELIZABETH DUCKHORN</b>		14. NAME OF HUSBAND OR WIFE <b>SUSIE YANOSCHEK</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. <b>486-16-7825<sup>a</sup></b>		17. INFORMANT Address <b>SUSIE YANOSCHEK 2852 WYOMING</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CHRONIC MYOCARDITIS.</b>		<b>2 mo.</b>
DUE TO (c) <b>CONGESTIVE FAILURE</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>527.1</b>		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.) <b>527.1</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
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 <b>11-1-52</b> to <b>12-15-60</b> and last saw him alive on <b>12-15-60</b> Death occurred at <b>2:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <b>Thomas H. Jones M.D.</b>		22b. ADDRESS <b>370, GRAND OAK SQ</b>		22c. DATE SIGNED <b>12/17</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>DEC 19, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Thomas H. Jones 2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 19 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Eleanor Province

Licensed Embalmer No. 340

P. O. Address 2906 9th

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