SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-~~[illegible]~~

FILED VS MAR 16 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2154 STATE FILE NUMBER 10585

AMENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b: 2 Weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Lutheran Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St.Louis
c. CITY OR TOWN: Mattese
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 4403 Butler Hill Road
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Pete Middle: T. Last: Cika

4. DATE OF DEATH: Month: March Day: 2 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 6-16-1888
9. AGE (last birthday): 72
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): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (City and state or country): Roumania
12. CITIZEN OF WHAT COUNTRY: U S A

13a. FATHER'S NAME: Unknown Cika
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Mary

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: Geo.H.Cika Address: Rt.8 Box 585 Mehlville 28,Mo.

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): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 4 years.
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): Atelectasis; Bronchopneumonia bilateral

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 10-9-56 to 3-2-61 and last saw ~~her~~ him alive on 3/2/61
Death occurred at 3.30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Albert H. Cason M.D. (Degree or title)
22b. ADDRESS: 4401 Hampton Ave.
22c. DATE SIGNED: 3/3/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-6-1961
23c. NAME OF CEMETERY OR CREMATORY: Assumption Cemetery
23d. LOCATION (City, town, or county) (State): Mattese St.Louis Co.Mo.

24. FUNERAL DIRECTOR: C.Hoffmeister Mortuaries ADDRESS: 7814 S.Broadway
25. DATE RECD. BY LOCAL REG.: MAR 3 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Lewis C. Hoffman

Licensed Embalmer No. 3871

P. O. Address 7814 S. Bre

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.