MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED MAY 4 1961

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4095 STATE FILE NUMBER 61-015265

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED 3/

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b Over 39 yrs

c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State — Inside Limits Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location) 5400 Arsenal St. — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First Josephine Middle Last Hudecek

4. DATE OF DEATH Month Day Year April 28, 1961

5. SEX Female

6. COLOR OR RACE White

7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]

8. DATE OF BIRTH 11/1/83

9. AGE (last birthday) 77 yrs — 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

11. BIRTHPLACE (City and state or country) Csechoslovakia

12. CITIZEN OF WHAT COUNTRY Czechoslovakia

13a. FATHER'S NAME Thomas Cizl

13b. MOTHER'S MAIDEN NAME Therese Bleck

14. NAME OF HUSBAND OR WIFE CHARLES HUDECEK

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. NONE

17. INFORMANT STELLA NOVAK Address 5736 WINONA

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) Cerebral Vascular Accident

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerosis

DUE TO (c) 331X

INTERVAL BETWEEN ONSET AND DEATH

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 [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 August 21, 1925, to April 28, 1961 and last saw her/him alive on April 28, 1961

Death occurred at 9:05 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph Drew Callahan M.D.

22b. ADDRESS 5400 Arsenal St.

22c. DATE SIGNED 4/29/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE MAY 1, 1961

23c. NAME OF CEMETERY OR CREMATORY ST. PETER + PAUL CEM.

23d. LOCATION (City, town, or county) (State) ST. LOUIS

24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois

25. DATE RECD. BY LOCAL REG. MAY 1 1961

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 _____

Licensed Embalmer No. 4347

P. O. Address 2906 [illegible]

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.