

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023061
STATE FILE NUMBER

318 Primary Registration District No. 1003 Registrar's No. 6115

AMENDED FILED JUL 7 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Length of stay in 1b		c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <i>ST. ANTHONY HOSPITAL</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>2624 NEBRASKA.</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First: <i>ANASTASIA</i> Middle: <i>STELLA</i> Last: <i>RADIL</i>				4. DATE OF DEATH Month: <i>JUNE</i> Day: <i>29</i> Year: <i>1961</i>									
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>APR 8. 1884</i>		9. AGE (last birthday) <i>77</i>		IF UNDER 1 YEAR Months: Days: Hours: Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WORK</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (City and state or country) <i>MISSOURI</i>		12. CITIZEN OF WHAT COUNTRY <i>U-S-A</i>					
13a. FATHER'S NAME <i>ANTHONY PEKAREK</i>				13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				14. NAME OF HUSBAND OR WIFE <i>JOSEPH RADIL SR</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>JOSEPH RADIL SR. 2624 NEBRASKA</i>							
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			
IMMEDIATE CAUSE (a) <i>Acute Cardiac Abilitation</i>										<i>1 day</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <i>Yacenic poisoning</i>		<i>5 days.</i>	
DUE TO (c) <i>Sepsis Gonorrhea</i>										<i>14 mo.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Myocarditis</i>						PART III. If deceased was female was there a pregnancy in last 90 days. <i>593X</i>		<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 a.m. p.m.		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		COUNTY		STATE			
21. I attended the deceased from <i>September 8-58 June 19-61</i> and last saw her/him alive on <i>June 78-1961</i> Death occurred at <i>12:40 AM</i> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Joel Chlachal, M.D.</i>						22b. ADDRESS <i>2767 Gravois St</i>			22c. DATE SIGNED <i>6-30-61</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>JULY 1, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>RESURRECTION CEM.</i>			23d. LOCATION (City, town, or county) <i>ST. LOUIS Co., MO.</i>		(State)				
24. FUNERAL DIRECTOR <i>Thomas Kutis 2906 Gravois</i>				25. DATE RECD. BY LOCAL REG. <i>JUN 30 1961</i>		26. REGISTRARS SIGNATURE <i>Joel Smith, M.D.</i>							

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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gravo

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.