

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8977

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED OCT 19 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 mo. 24 days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3127 Locust St.
3. NAME OF DECEASED (Type or print) First Middle Last Maria Krejsa		4. DATE OF DEATH Month Day Year 9-25-61	

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-21-78	9. AGE (last birthday) 82	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) Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Bohemia	12. CITIZEN OF WHAT COUNTRY Unknown	
13a. FATHER'S NAME unk.		13b. MOTHER'S MAIDEN NAME Unk.		14. NAME OF HUSBAND OR WIFE		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Marie Rothwell	Address 4140 Lindell
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Generalized atherosclerosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) \_\_\_\_\_

DUE TO (c) 450.0

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)  
Uremia

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from 5-10-61 to 9-25-61 and last saw her/him alive on 9-25-61  
Death occurred at 12:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John J. Smith</i> (Degree or title)	22b. ADDRESS 5800 Arsenal St.	22c. DATE SIGNED 9/25/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9-28-61	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri	(State)
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24. FUNERAL DIRECTOR Cullen & Kelly	ADDRESS 7267 Natural Bridge	25. DATE RECD. BY LOCAL REG. SEP 28 1961	26. REGISTRAR'S SIGNATURE <i>Robert Smith, M.D.</i>
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**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 Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed James A. Lamone  
Licensed Embalmer No. 4142  
P. O. Address St. Louis

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.