

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH - 61-042757

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10755 STATE FILE NUMBER

FILED NOV 28 1961

1. PLACE OF DEATH a. COUNTY St. Louis, Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN Webster Groves,	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin DesLoge Hosp.		d. STREET ADDRESS (If outside, give location) 422 E. Glendale Rd.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Daniel Middle John Last Novak			4. DATE OF DEATH Month Nov. Day 17 Year 1961		
5. SEX M.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/15/27	9. AGE (last birthday) 34	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchandising		10b. KIND OF BUSINESS OR INDUSTRY Wohl Shoe Co.		11. BIRTHPLACE (City and state or country) Johnstown, Pa.	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME John F. Nowak		13b. MOTHER'S MAIDEN NAME Amelia Havel	
14. NAME OF HUSBAND OR WIFE Julia Novak		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. INFORMANT Mrs. Julia Novak, 422 E. Glendale		Address			

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 ARTERY Insufficiency ^{Angiogram} ^{pluribus}			INTERVAL BETWEEN ONSET AND DEATH 2 + 1/2
DUE TO (b) Aortic stenosis & Insufficiency.			2 + 1/2
DUE TO (c) Rheumatic fever.			20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 411X			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N <input type="checkbox"/> 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 4:40 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 Johnstown, Pa.	COUNTY Pa.	STATE
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21. I attended the deceased from 11/17/61 to 11/17/61 and last saw him alive on 11/17/61 Death occurred at 4:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE C. Bellus (Deceased or title)	22b. ADDRESS 1325 S GRAND BLVD SALY	22c. DATE SIGNED 11/18/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov. 20, 1961	23c. NAME OF CEMETERY OR CREMATORY Grandview	23d. LOCATION (City, town, or county) Johnstown, Pa.	(State)
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24. FUNERAL DIRECTOR Parker-Aldrich, Webster Groves	25. DATE RECD. BY LOCAL REG. NOV 20 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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State of Iowa
 Department of Health
 #22 W. George St.
 Des Moines, Iowa
 John T. Lusk
 State Embalmer
 John T. Lusk
 State Embalmer
 John T. Lusk
 State Embalmer

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 Leslie Welch
 Licensed Embalmer No. 4395
 P. O. Address Walter Groves

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.