

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318 1003 12089 -61-046612  
STATE FILE NUMBER

AMENDED

Registration District No. FILED JAN 5 1962 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ALEXIAN BROS HOSP.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4601 Alaska Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>JOSEPH MARICIC</u>			4. DATE OF DEATH Month <u>December</u> , Day <u>23</u> , Year <u>1961</u>			
First	Middle		Last	Month	Day	Year

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/85</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Molder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Foundry</u>	11. BIRTHPLACE (City and state or country) <u>Novi Vindol, Yugoslavia U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>Ivan Maricic</u>	13b. MOTHER'S MAIDEN NAME <u>Rozaria Sokolich</u>	14. NAME OF HUSBAND OR WIFE <u>Marija Maricic</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	17. INFORMANT <u>Marija Maricic 4601 Alaska Ave</u>	Address
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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) <u>Pneumonia left base</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ca. prostate</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.) <u>493XH</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year
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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 Feb 1957 to Dec 23 1961 and last saw <sup>her</sup><sub>him</sub> alive on Dec 22, 1961  
Death occurred at 3P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. Nachweyn M.D.</u>	22b. ADDRESS <u>4065 S. Grand</u>	22c. DATE SIGNED <u>12/24/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/27/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery St. Louis County, Mo.</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <u>CHULICK UND. CO. 1722 S. Jefferson</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 26 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH  
ST. LOUIS, MISSOURI  
OFFICE OF THE STATE EMBALMER  
ST. LOUIS, MISSOURI  
STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH  
ST. LOUIS, MISSOURI  
OFFICE OF THE STATE EMBALMER  
ST. LOUIS, MISSOURI

**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 Van M. Szymon

Licensed Embalmer No. 4343

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.