

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024840

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **6503**

**FILED JUL 8 1962**

VS 300  
Rev. 4/59

1  
2 *2/5*  
3  
4 *1*  
5 *Z*  
6  
7 *2*  
8 *2*  
9  
10  
11  
12 *73-0*  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		c. CITY OR TOWN <b>St Louis Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Anthonys Hosp</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5417 Tennessee Ave</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Kratochvil</b> Last			4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1962</b>			5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/25/85</b>	9. AGE (last birthday) <b>76</b>		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) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (City and state or country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>									
13a. FATHER'S NAME <b>J. Svoboda</b>				13b. MOTHER'S MAIDEN NAME <b>Unk</b>				14. NAME OF HUSBAND OR WIFE <b>Frank (Deceased)</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Anne Kratochvil 5417 Tennessee</b>				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) <b>Acute Cardiac Arrhythmia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma Liver 1561</b>										<b>8 mos.</b>							
DUE TO (c) <b>Acute Cardiac arrhythmia</b>										<b>4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Melanosis of cancer</b>										PART III. If deceased was female was there a pregnancy in last 90 days. <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 checked="" 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 <b>Aug 8-1961</b> to <b>June 30-1962</b> and last saw her him alive on <b>June 30, 1962</b> Death occurred at <b>1145 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree, or title) <b>J. M. Lambert M.D.</b>					22b. ADDRESS <b>2767 Garrio</b>					22c. DATE SIGNED <b>7-2-62</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7/8/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>										
24. FUNERAL DIRECTOR <b>Moydell Funeral Home 1926 Allen</b>					ADDRESS		25. DATE RECD. BY LOCAL REG. <b>JUL 2 1962</b>										
					REGISTRAR'S SIGNATURE <b>Robert M. D.</b>												

USE BLACK INK OR TYPEWRITER RIBBON

73

**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 *John J. Haines*

Licensed Embalmer No. 4108

P. O. Address *St. Louis, Mo.*

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.