

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-003731

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 879

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St. Louis</b>		a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>17 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5959 Riverview Blvd.</b>	
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)			4. DATE OF DEATH
First Middle Last <b>BARNEY (none) KOVACH</b>			Month Day Year <b>Jan. 25. 1963</b>
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
<b>Male</b>	<b>White</b>		<b>8-8-85</b>
9. AGE (last birthday)		IF UNDER 1 YEAR IF UNDER 24 HR	
<b>77</b>		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
<b>Proprietor</b>		<b>Freight Lines</b>	<b>Hungary</b>
12. CITIZEN OF WHAT COUNTRY		<b>U.S.A.</b>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
<b>August Kovach</b>		<b>Ethel Paksi</b>	<b>Mary Kovach</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
<b>No</b>		<b>40-A</b>	<b>Mrs. Mary Kovach, St. Louis, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Acute Cardiac Ischemiation</b>			<b>Minutes</b>
DUE TO (b) <b>Cerebral Apoplexy</b>			<b>Days</b>
DUE TO (c) <b>Diabetes Mellitus</b>			<b>Weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days.
<b>Acute Uremia</b>			<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.)	
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 <b>1-16-63</b> to <b>1-25-63</b> and last saw her/him alive on <b>1-25-63</b>			
Death occurred at <b>12:45 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
<b>Nicholas J. Stale, MD</b>		<b>7150 Natural Bridge Rd.</b>	<b>1/26/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>1-28-63</b>	<b>Robinson Cemetery</b>	<b>Pocahontas, Illinois</b>
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<b>John J. Kassly, E. St. Louis, Ill.</b>		<b>JAN 28 1963</b>	<b>Paul Smith, M.D.</b>

VS 300  
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DATE AMENDED

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**56**

**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 John J. Cassidy III

Licensed Embalmer No. 5039

P. O. Address E. 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.