

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030183

FILED VS AUG 18 1959 316

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 315

DED

|   |  |   |  |  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Francois County</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b> |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Bonne Terre, Mo.</b>  |  | Length of stay in 1b<br><b>Life</b>   |  | c. CITY OR TOWN <b>Bonne Terre, Mo.</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Residence</b>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>Bonne Terre, Mo. RR # 2</b>  |  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Thomas</b> Middle <b>Frank</b> Last <b>Kalal</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Aug</b> Day <b>10</b> Year <b>1959</b>  |  |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11/11/1880</b>  | 9. AGE (last birthday)<br><b>78</b>                                      | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>30</b>  | IF UNDER 24 HR<br>Hours <b></b> Min. <b></b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>Bonne Terre, Mo.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   |
| 13a. FATHER'S NAME<br><b>Frank Kalal</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Anna Unknown</b>                                     |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Mary Magura</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   | 16. SOCIAL SECURITY NO.  | 17. INFORMANT<br>Address<br><b>Mary Kalal, Bonne Terre, Mo. RR#2</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia due to chronic nephritis</b>  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>   |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   |  |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Arteriosclerotic heart disease</b>  |  |   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a.m. _____<br>p.m. _____   |  | Month, Day, Year _____  |  |  |  |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>1954</b> to <b>Aug. 5, 1959</b> and last saw her/him alive on <b>Aug. 5, 1959</b><br>Death occurred at <b>10:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |  |  |   |
| 22a. SIGNATURE<br><i>Frank Kalal</i> (Degree or title)  |  |   |  | 22b. ADDRESS<br><b>Bonne Terre, Mo.</b>  |  |  | 22c. DATE SIGNED<br><b>8-11-59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/13/59</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Catholic Cem.</b>                           |  | 23d. LOCATION (City, town, or county) (State)<br><b>Bonne Terre, Mo.</b> |  |   |
| 24. FUNERAL DIRECTOR<br><b>Sparks Funeral Home, Bonne Terre, Mo.</b>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>Aug. 11, 1959</b>   | 26. REGISTRAR'S SIGNATURE<br><i>Ether Rudloff</i>                        |  |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 8 1 5 30

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed John N. Shipman

Licensed Embalmer No. 4881

P. O. Address Bismarck

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.