

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

6309

**1. PLACE OF DEATH**

County.....

Registration District No. 791

File No. 1497

Township.....

Primary Registration District No. 1003

Registered No.

City *St. Louis, Mo.*

(No. *Baptist Hospital Garrison & Franklin Ave.*)

**2. FULL NAME**

*Paul Ivanovich*

(a) Residence. No. *65305 Mitchell Av. 4*

(Usual place of abode)

Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

*male*

4. COLOR OR RACE

*white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

*Mary Ivanovich*

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

*Jan 25-1874*

7. AGE

*52*

YEARS

MONTHS

*18*

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

*Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer).

*19*

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

*Croatia*

10. NAME OF FATHER

*John Ivanovich*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Croatia*

12. MAIDEN NAME OF MOTHER

*Helen Ivanovich*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Croatian*

14.

INFORMANT (Address)

*Mrs. M. Ivanovich  
6535 Mitchell Av.*

15.

FILED

*FEB 13 1927*

*Max B. Starkeroff*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR)

*2-13 1927*

17.

I HEREBY CERTIFY, That I attended deceased from

*Jan 17, 1927*

to

*Feb 7, 1927*

that I last saw him alive on *Feb 12, 1927*, and that death occurred, on the date stated above, at *5 a* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS

*Carcinoma Liver*

*Probable* (duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY (SECONDARY)

*4 B* (duration) *0* yrs. *0* mos. *0* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

*Home*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

*Clinical & Lab*

(Signed) *R. E. Owen* M. D.

*713 127* (Address) *University Club Bldg*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*SS. Peter & Paul's Cem.*

*Feb 15 1927*

20. UNDERTAKER

ADDRESS

*E. J. Schmur*

*3125 Lafayette Av.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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