

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No. **31797**

Registered No. **9154**

2. FULL NAME **Daniel Lurik**

(a) Residence. No. **1379 Union Ave.** **5** Ward.

(Usual place of abode)

(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

2. SEX **Male** **4. COLOR OR RACE** **White** **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Eliza Lurik**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 30, 1851**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 **4** **13**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Merchant**
(b) General nature of industry, business, or establishment in which employed (or employer) **Picture framing and supplies**
(c) Name of employer **Joliet**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Joliet Illinois**

10. NAME OF FATHER **Thomas Lurik**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

14. INFORMANT (Address) **Harry O. Lurik 1379 Union Ave**

15. FILED **NOV 14 1927** **Marie Starkloff** Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10-13-27** 19

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred on the date stated above, at **3-05 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy

CONTRIBUTORY (SECONDARY) **M. M. A.**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....
20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
10/14/27 (Signed) **Wm. D. ...** (Address) **222 ...**

*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 **Valhalla Crematory** **DATE OF BURIAL** **Oct. 16 1927**

20. UNDERTAKER **Edw. Shepard** **ADDRESS** **5921 Easton Ave**

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

W. 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.

