

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

Do not use this space.

19148

1. PLACE OF DEATH

County.....

Registration District No.....

**791
1003**

File No.....

Registered No.....

5572

Township.....

Primary-Registration District No.....

City.....

(No.)

St.....

Ward.....

2. FULL NAME

JOSEPH NOVAK

(a) Residence. No.....

(Usual place of abode)

St.....

Ward.....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **30** yrs.

mos.

ds.

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

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

Dionisiana

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

July 1 - 1878

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ___ hrs. or ___ min.

49

10

19

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

10. NAME OF FATHER

Martin Novak

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

12. MAIDEN NAME OF MOTHER

Catherine Gutman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

14. INFORMANT

(Address)

City Hospital

15. FILED

NOV 22 1923

Wm C. Frank
REGISTRAR

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

May 20 1928

17.

I HEREBY CERTIFY That I attended deceased from *May 15* 19*28* to *May 20* 19*28* that I last saw *him* alive on *May 20* 19*28* and that death occurred, on the date stated above, at *10:45 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

CONTRIBUTOR (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Henry C. Westerman, M.D.*

(Address) *City Hospital*
*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

Cabany County

May 28 28

20. UNDERTAKER

ADDRESS

Central

1841 Cass.

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

R. 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.

Nov 11