

**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. 3003
 City St. Louis (No. 5600 Arsenal)

File No. 28624
 Registered No. 8076
 St. 24th Ward

2. FULL NAME

JOE MACKICH
 (a) Residence. No. 6828 Arsenal St., 3 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 38 yrs. 0 mos. 12 ds. How long in U.S., if of foreign birth? 15 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 Mrs. Sophia Mackich

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 25, 1890

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>38</u>	<u>10</u>	<u>12</u>	

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Robert Mackich

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

12. MAIDEN NAME OF MOTHER Kate Drezich

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

14. INFORMANT Mrs. Sophia Mackich
 (Address) 6828 Arsenal Street

15. FILED 116-8-1923 Mar C. Stanley REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 7 19 28

17. I HEREBY CERTIFY That I attended deceased from Aug 5 19 28 to Aug 7 19 28 that I last saw him alive on Aug 7 19 28 and that death occurred, on the date stated above, at 8:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis, Meningococcic (4 d)
Nephritis, Acute Hemorrhagic (4 d)
Malaria (7 days)
 (duration)..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 6828 Arsenal
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No. DATE OF.....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Clinical + Laboratory
 (Signed) George Harrison M. D.

8/7 19 28 (Address) ISOLATION 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 Mount Hope DATE OF BURIAL Aug 9 19 28

20. UNDERTAKER Herb. Moyall ADDRESS 136 Allen

PARENTS

OF
PAS

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City.....
St. Louis

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *8076*
St. Ward.....

2. FULL NAME

(a) Residence. No. St. 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.

Joe Mackich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *M*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 23, 1890*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
37 *10* *12*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED *OCT 10 1928* *Max B. Starkeff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 7 1928*

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.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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)....., M. D.
, 19 (Address)

*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

19

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-28624

1914.10.10