

**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. 3164, Jordan Ave) St. 5252 (Ward)

19645

2. FULL NAME

William Krejci

(a) Residence. No. 1841 S 12 St., 23 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U.S., if of foreign birth 50 yrs. mos. da.

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 Elizabeth Krejci
 (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 | 10 | 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gen. Merchant
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bohemia
 (STATE OR COUNTRY)

10. NAME OF FATHER William Krejci

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

12. MAIDEN NAME OF MOTHER Rose Slavac

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

14. INFORMANT Elizabeth Krejci
 (Address) 1841 S 12 St -

15. MAY 11 1929 Mar C. Stanley
 FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 19 29

17. I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1927, May 9th, 1929 that I last saw him alive on May 8th, 1929, and that death occurred, on the date stated above, at May 9th 7:45

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral apoplexia

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. da.

Chronic Brights disease (duration) yrs. mos. da. 1 da.
 CONTRIBUTORY (SECONDARY) Nephrosis (duration) yrs. mos. da. 8 mos. 8 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? 129A DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Nikolas Bender, M. D.

May 10 1929 (Address) 1012 Seyer Ave

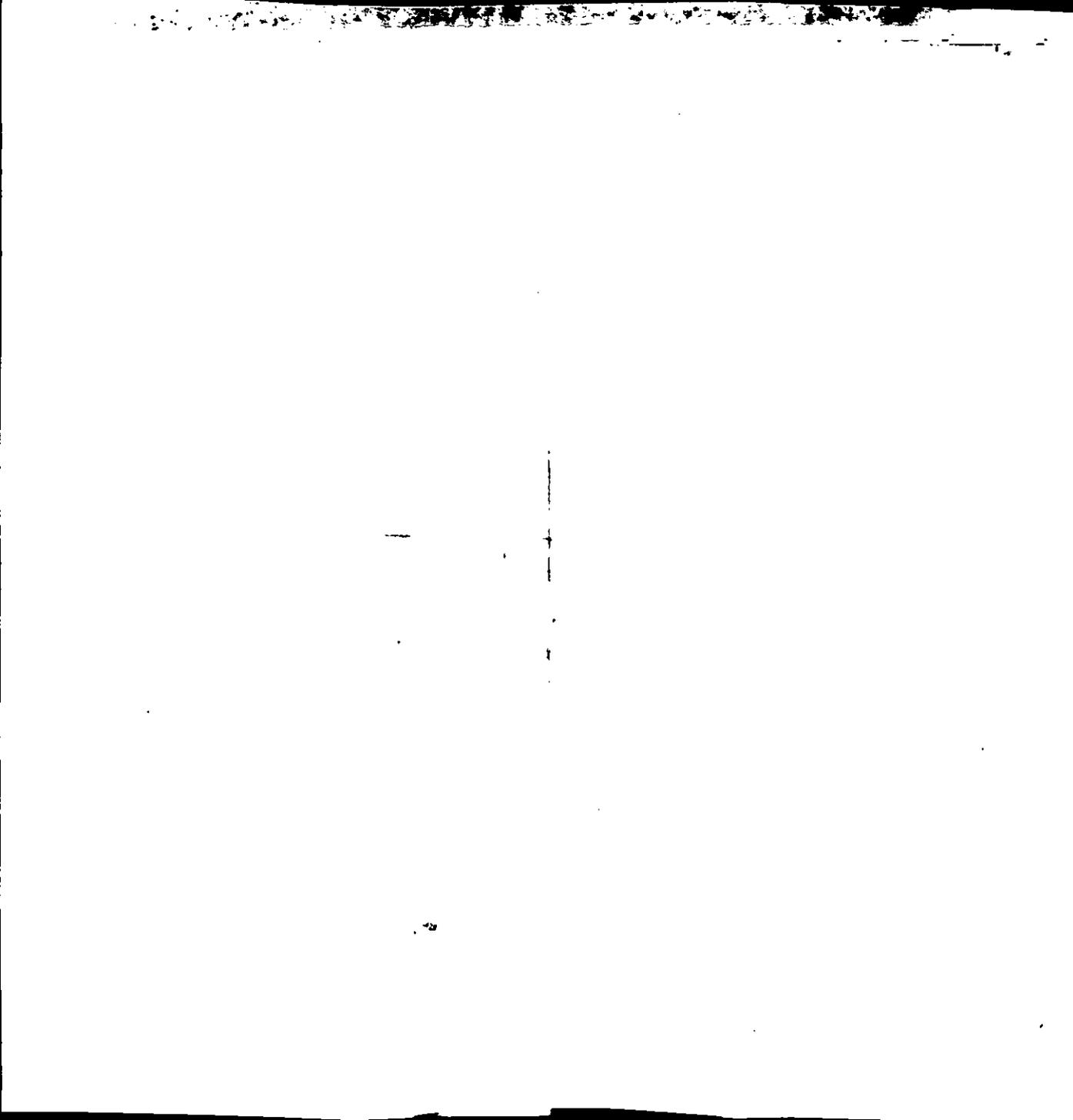
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL CREMATION, OR REMOVAL DATE OF BURIAL

St Peter & Paul May 13 1929

20. UNDERTAKER ADDRESS

Thos Kutis 2906
Gravois Ave



**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..... Registration District No. 791 File No.....
Township..... Primary Registration District No. 1003 Registered No. 3232
City St Louis (No.....) St..... Ward.....

2. FULL NAME

William Krejci
(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.

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) July 7 (1865)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
64 10 2

8. OCCUPATION OF DECEASED

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

PARENTS

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) Wm Krejci

15. FILED JUL 12 1929 Wm Krejci REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 1929

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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (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)....., 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

1929
57961#
#19645