

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

Do not use this space.

20619
~~20417~~
File No. _____
Registered No. **5356**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **3168 Pennsylvania St.**)

2. FULL NAME

Matthew J. Duchek
(a) Residence. No. **3168 Pennsylvania**, **214** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred **50** yrs. mos. ds. How long in U. S., if of foreign birth? **50** 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 Duchek**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 27, 1873**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56. 10. 4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Auto Painter**
(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 **Joseph Duchek**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Bohemia**
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER **Mary Radec**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Bohemia**
(STATE OR COUNTRY)

14. INFORMANT **Mary Duchek**
(Address) **3168 Pennsylvania**

15. FILED **JUN 2 1939** **Eric C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 2 1930**
17. **No Physician in Attendance**
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 **6:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy

CONTRIBUTORY (SECONDARY) **7401**
(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? **yes**
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **J. L. Kerret, M.D.**

, 19____ (Address) **Dep. Corner**
*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 **St. Peter & Paul** DATE OF BURIAL **June 5 1930**

20. UNDERTAKER **Thos Kutis** ADDRESS **2906 Epprais**

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.

