

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

Do not use this space.

24507

**1. PLACE OF DEATH**

County.....  
Township.....  
City St. Louis (No. 2103)

Registration District No. 791  
Primary Registration District No. 1003  
Menard St

File No.....  
Registered No. 6661  
St..... Ward.....

**2. FULL NAME**

Anna Bukorin

(a) Residence. No. 2103 Menard 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 yrs. mos. / ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9-30

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
1

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. none  
(b) General nature of industry, business, or establishment in which employed (or employer). none  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER John Bukorin  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Jugo Slavre  
12. MAIDEN NAME OF MOTHER Anna Mozlak  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Jugo Slavre

14. INFORMANT John Bukorin  
(Address) 2103 Menard

15. FILED 11/19/30 May C. Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 16 1930

17. No Physician attended  
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: 3 P.

Patient Foramen  
Osse  
1 157c (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 159 B  
(duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) G. W. Ferrier, M.D.  
7/11/30 (Address) Dep. Coron

\*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 July 11 1930

20. UNDERTAKER Mr. G. Moydell ADDRESS 1926 Allen

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

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.

