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

Do not use this space.

24609

File No. 6767

Registered No.

**1. PLACE OF DEATH**

County ..... Registration District No. 791 1000

Township ..... Primary Registration District No. .....

City St. Louis (No. City Hospital St. ..... Ward)

6256

**2. FULL NAME** Frank Berlica

(a) Residence. No. 1705 So 10th St., 23 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| male | white | single |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 13 - 1880

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 49 | 7 | 28 | |

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) Grocery store
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Joe Berlica

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

12. MAIDEN NAME OF MOTHER Anna Unknown

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

14. INFORMANT Hospital Information E. Rowan
(Address) City Hospital

15. FILED JUL 12 1930 Max C. Parker REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11 1930

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 11, 1930 that I last saw him alive on July 11, 1930, and that death occurred, on the date stated above, at 2:37 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Delirium Tremens
15A
15B (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Chronic Alcoholism (duration) ? yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 1705 So 10th st
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Benj Margulous, M. D.
7/11, 1930 (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 |
|---|---|
| Ind. St. Marcus | 7-12 1930 |
| 20. UNDERTAKER | ADDRESS |
| W. C. Maydell | 1926 Allen |

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.