

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

2835

1. PLACE OF DEATH
 County St. Louis County Registration District No. 1123
 Township DELET Primary Registration District No. 2225 File No. _____
 City _____ (No. Mo. St. Rose Hospital) Registered No. 7 St. _____ Ward _____

2. FULL NAME John Sutka
 (a) Residence 2709 South 13th 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 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. Emma Sutka
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 21 - 1886
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 45 8 13
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work laborer 6'
 (b) General nature of industry, business, or establishment in which employed (or employer) Messmer Brass & Co.
 (c) Name of employer _____

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

10. NAME OF FATHER Joseph Sutka
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Europe
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Wm. Martin
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Europe
 (STATE OR COUNTRY) Australia

14. INFORMANT Emma Sutka
 (Address) 2709 - 13th

15. FILED 18 19 31 L. C. Obrock
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/3/31 (4:20 AM) 1930
 17. I HEREBY CERTIFY, That I attended deceased from 12/3/30 1930
 that I last saw him alive on 11/30 1930 and that death occurred, on the date stated above, at 4:20 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23A Tuberculosis (chronic) fibrocascous consolidation (lung)
 (duration) yrs. 9 mos. ds.

CONTRIBUTORY (SECONDARY) Tuberculosis pneumonia of left lung
 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) Charles W. Ehlers, M. D.
 (Address) 910 S. Broadway

*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 Jan 12 1931

20. UNDERTAKER Wacker Helder ADDRESS 2331 S Broadway

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.

96
44-8-12

BE should be stated as
and Exact statement

**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 St. Louis Registration District No. 1123 File No.
 Township Carondelet Primary Registration District No. 6248 Registered No. 4
 City (No.) St. Ward)

2. FULL NAME

John Dutka
 (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) Apr 21-1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
44 8 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)

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)

15.

FILED Aug 31 19 L. C. Obzide REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1931

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and that (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) (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

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

SUPPLEMENTARY

S-2835