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.

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

Do not use this space.

35711

File No.

Registered No. 10185

1. PLACE OF DEATH

County

Registration District No. 79

Township

Primary Registration District No. 100

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

11584

2. FULL NAME Joseph Pesek

(a) Residence, No. 2433 So. 18th 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 Fifty 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) Sept. 21-1931

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
		11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. nil

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

FATHER

13. NAME Joseph Pesek

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

MOTHER

15. MAIDEN NAME Louise Glikert

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

17. INFORMANT (ADDRESS) Hospital Information Grace Kopp City Hospital

18. BURIAL, CREMATION, OR REMOVAL
PLACE St Peter & Paul DATE Oct 3 1931

19. UNDERTAKER (ADDRESS) Wm. C. Moydell 1926 Cherry

20. FILED -3 1931 19 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 2nd, 1931

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1st, 1931, to Oct-2nd, 1931

I last saw him alive on Oct-2nd, 1931. Death is said to have occurred on the date stated above, at 10.00 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
161B	
Icterus	
neonatorum	

Other contributory causes of importance:

161B

Name of operation Clinical Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Jerome Simon, M. D.

(Address) City Hospital

Pese

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

PLACE OF DEATH.

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. 10185

City..... (No. City Hosp. ..... St. ..... Ward)

2. FULL NAME Joseph Pesek

(a) Residence. No. 2433 S 18 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 21/1931

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.
		11	

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) Gelena Ono
(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 NOV -9 1931 Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 2 1931

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:

.....

.....

.....

.....(duration).....yrs. .....mos. .....ds.

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

SUPPLEMENTARY

...m of information should be carefully suppl... ...l be stated EXACTLY. PHYSICIANS sh... ...ATH in plain terms, so that it may be prope... Exact statement of OCCUPATION is very i...

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

S-35711