

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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No. *701*  
Township..... Primary Registration District No. *1008*  
City *St. Louis* (No. *City Hospital*)

File No. *7494*  
Registered No. *1449*  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. *1709 Lafayette* Ward. *13*  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *6* yrs. *0* mos. *0* 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) *single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 15 - 1926*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*6* *8* *25*

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, Miss.*

13. NAME *Nick Kulick*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Poland*

15. MAIDEN NAME *Frances Duggach*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Poland*

17. INFORMANT (ADDRESS) *City Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *New St. Paul* DATE *Feb 13* 19*33*

19. UNDERTAKER (ADDRESS) *Chulick Und.*

20. FILED *FEB 11 1933* Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 9th 1933*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 1st 1933* to *Feb 9th 1933*

I last saw him alive on *Feb 9th 1933* Death is said to have occurred on the date stated above, at *4:15 PM*

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

*acute myocarditis* Date of onset *Feb 1*  
*100% (post-diphtheria)*  
*1120 10*

Other contributory causes of importance:  
*Paralysis pharynx + 1st shoulder Jan 10*  
*(post-diphtheria)*

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? *yes*

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) *J. J. Balger*, M. D.  
(Address) *City Hospital*

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.

MARGIN RESERVED FOR BINDING

Public.