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.

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. 791 File No. 22013

Township ..... Primary Registration District No. 1003 Registered No. 5764

City St. Louis (No. 5W S. Kingshighway, St. Louis Children Hosp. Ward)

2. FULL NAME Thomas Chuccalovich

(a) Residence, No. 2543 No. 31st St., NR Ward. Fairmont, Ill.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 5 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-21-29.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
4	11	18	

OCCUPATION

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

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

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) Ill.

FATHER

13. NAME Simon

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Servia

MOTHER

15. MAIDEN NAME Mary Gnvelda

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hungary

17. INFORMANT (ADDRESS) J. McIlvain 5W S. Kingshighway

18. BURIAL, CREMATION, OR REMOVAL

PLACE Cass St. Louis Ill. DATE June 9 1934

19. UNDERTAKER (ADDRESS) John Kasely Cass St. Louis Ill.

20. FILED ..... 19.. J. S. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-9-34, 19

22. I HEREBY CERTIFY, That I attended deceased from 6-4-34, 19.., to 6-9-34, 19..

I last saw him alive on 6-9-34, 19.. Death is said to have occurred on the date stated above, at 1:35 a.m.

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

	Date of onset
Tuberculous Meningitis	10 days

140

Other contributory causes of importance:

Tuberculosis of ~~[illegible]~~ mediastinal lymph nodes ?

Name of operation None Date of .....

What test confirmed diagnosis? L. P. 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) Stanley C. Harrison, M. D.

(Address) 500 S. Kingshighway

100M-11-24-33