

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.

NOV 4 1936
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

39101

1. PLACE OF DEATH

County..... Registration District No. **1008**
Township..... Primary Registration District No.
City **St. Louis, Mo.** (No. **St. Anthony's Hospital**) St. Ward)

File No.
Registered No. **10132**

2. FULL NAME **Marie Baier Prokes**

(a) Residence, No. **5141 Rosa Ave.** St. **2** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **45** yrs. **5** mos. **3** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	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 Charles A. Prokes				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 5, 1881				
7. AGE	YEARS 55	MONTHS 5	DAYS 3	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as aptiner, sawyer, bookkeeper, etc. Housewife			
	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.**

13. NAME **Joseph F. Baier**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Czecho-Slovakia**

15. MAIDEN NAME **Charlotte Korensky**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Czecho-Slovakia**

17. INFORMANT **Charles A. Prokes**
(ADDRESS) **5141 Rosa Ave**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **St. Peter & Paul** DATE **Oct. 8** 19**36**

19. UNDERTAKER **J. C. Maydell**
(ADDRESS) **1926 Wilson Way**

20. FILED **OCT 7 1936**
J. Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 6th** 19**36**

22. I HEREBY CERTIFY, That I attended deceased from **Aug 25th** 19**36** to **Oct 6th** 19**36**

I last saw him/her alive on **Oct 6th** 19**36**. Death is said to have occurred on the date stated above, at **4:20^a** m.

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

Subacute Fibrinous Pericarditis with Effusion
(Origin undetermined) **90**

Other contributory causes of importance:

Fluoral Effusion
Acute Pancreatic necrosis
Acute Nephritis Cause of ?
Name of operation **Parathyroidectomy** Date of **10/20/36**

What test confirmed diagnosis? **Urinalysis** 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) **H. C. Kropfer**, M. D.

(Address) **3801 S. Broadway**

