

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.

OCT 14 1937

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

32308

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis Mo.** (d) Street No. **1433 S. 10th St.** Registered No. **8362**
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Barbara Polovich**

(a) Residence, No. **1433 S. 10th St.** St. **30** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 **Ignatz Polovich**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb 2 1864**
7. AGE YEARS **73** MONTHS **7** DAYS **1** If LESS than 1 day, ... hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
9. Industry or business in which work was done, as 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) **Austria**
(STATE OR COUNTRY)

13. NAME **Michael Ehrhardt**

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

15. MAIDEN NAME **Unknown**

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

17. INFORMANT **Ignatz Polovich**
(ADDRESS) **1433 S 10th St**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **New St. Marons** DATE **Sept 6th**

19. FUNERAL DIRECTOR **Thos. Dubis**
(ADDRESS) **2906 Gravois Ave**

20. FILE **SEP 5 1937** **J. Bredeck**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept 3 1937**

22. I HEREBY CERTIFY, That I attended deceased from **August 19th 1937** to **Sept. 3rd 1937**
I last saw him alive on **Sept 3rd 1937**. Death is said to have occurred on the date stated above, at **2nd P. M.**
The principal cause of death and related causes of importance were as follows:

Carcinoma of stomach

Other contributory causes of importance:

Dilat. of heart.

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

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) **W. D. Rubin** M. D.
(Address) **1800 S. Broadway**

STATEMENT BY LICENSED EMBALMER

I, Thos KUTIS, Licensed Embalmer No. 1619

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

Thos KUTIS L. E. 1619

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Thos Kutis

Licensed Embalmer No. 1619

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)