NOV 16 1937

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

37376

1. PLACE OF DEATH
County: Carter — Registration District No.: 6405 — File No.: 18
Township: Johnson — Primary Registration District No.: 5208 — Registered No.: 41
City: ..... (No. ..... St. ..... Ward)

2. FULL NAME: Theresa Papaiak
(a) Residence. No. Carter Co Mo (Budapest) St. ..... Ward. (If nonresident give city or town and State)
(Usual place of abode) Grandville Star Route
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? 41 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jany 15th 1862

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	9	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Budapest
(STATE OR COUNTRY): Austria

PARENTS
10. NAME OF FATHER: George Kopchock
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Budapest
(STATE OR COUNTRY): Austria
12. MAIDEN NAME OF MOTHER: Theresa — —
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Austria

14. INFORMANT: Theresa Tator
(Address) 1572 La Fayette Ave St Louis Mo

15. FILED: 10/25 1937 Alexander Johnston Mo
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 24th 1937

17. I HEREBY CERTIFY, That I attended deceased from Sept. 17th, 1937, to Oct. 3rd, 1937, that I last saw her alive on September 17th, 1937, and that death occurred, on the date stated above, at 3 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis with dropsy. (Cardio Renal Disease)
131
(duration) One yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Old age infirmities and rapid heart (duration) ..... yrs. 3 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED at place of death
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No. DATE OF ✓
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Elijah A. Colley, M. D
, 19 (Address) R Not. Ellsinore Mo.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Budapest Cemetery, Carter Co Mo
DATE OF BURIAL: Oct 27 1937

20. UNDERTAKER: W C Craye
ADDRESS: Van Buren Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1. PLACE OF DEATH

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

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

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... 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	4. COLOR OR RACE	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)

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

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) .....
(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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS