

REC'D OCT 12 1938

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

30922  
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. **St Anthony Hospital** Registered No. **8359**  
(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 **Johanna Vit**  
(a) Residence, No. **3170 Oregon Ave.** St. **24** (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Frank Vit**  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 14 1877**  
7. AGE YEARS **61** MONTHS **4** DAYS **9** IF LESS than 1 day, .....hrs. or .....min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-22 1938**  
22. I HEREBY CERTIFY, That I attended deceased from **7/30**, 19**37**, to **9/23**, 19**38**  
I last saw h. **alive on 9/23**, 19**38** Death is said to have occurred on the date stated above, at **10 A.** m.  
The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**  
9. Industry or business in which work was done, as saw mill, bank, etc. **Housewife**  
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

*Carcinoma of sigmoid flexurae perforation + pelvic abscess*  
Date of onset **Several months**  
Other contributory causes of importance: **Mild diabetes mellitus Secondary anaemia**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Bohemia**

FATHER 13. NAME **William Pivnicek**  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Bohemia**

MOTHER 15. MAIDEN NAME **Unknown**  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Bohemia**

Name of operation **Exp. Inf. drainage** Date of **9/20/38**  
What test confirmed diagnosis? **Exp. lab.** Was there an autopsy? **yes**

17. INFORMANT (ADDRESS) **Emily Vit 3170 Oregon Ave.**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? **no** 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.

18. BURIAL, CREMATION, OR REMOVAL PLACE **S.S. Peter & Paul** DATE **Sept 26** 19**38**

Manner of injury.....  
Nature of injury.....

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

24. Was disease or injury in any way related to occupation of deceased? **no**  
If so, specify.....  
(Signed) **Wm. J. McKeown** M. D.  
(Address) **1040 Emmet**

20. FILED **SEP 24 1938** Local Registrar.

A. 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.

**STATEMENT BY LICENSED EMBALMER**

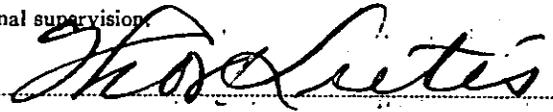
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

**THOS. KUTIS.** .....

or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed.....



Licensed Embalmer No. **1619** .....

P. O. Address **2906 Gravois Ave.** .....

**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.)**

**If this body is not embalmed, above space should be left blank.**