

REC'D FEB 10 1939

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

679  
Do not use this space.

## 1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City St. Louis, Mo. (d) Street No. 4433 Louisiana Ave. St. 791  
(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

(a) Residence, No. 4433 Louisiana Ave. St. 15 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*writes the word*) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 19, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from Jan 2 1939 to Jan 19 1939  
I last saw him alive on Jan 17 1939. Death is said to have occurred on the date stated above, at 10 P.M.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Abt. 1867

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
Abt. 72 Unknown

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

*Cerebral Hemorrhage*  
*arteriosclerosis*  
Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Czechoslovakia

Other contributory causes of importance:

13. NAME Michael Kalista

*High Arterial Hypertension*  
*Chronic Arteriosclerosis*

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

Name of operation..... Date of.....

15. MAIDEN NAME UnknownWhat test confirmed diagnosis?..... Was there an autopsy? No16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown23. 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)17. INFORMANT Anna Krentz  
(ADDRESS) 4433 Louisiana, Ave.

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Mo. Crematory DATE 1/23/39

Manner of injury.....

19. FUNERAL DIRECTOR (NAME) Wm. C. Moydell  
(ADDRESS) 1926 Allen Ave.24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify.....20. FILED JAN 23 1939(Signed) J. W. Downing M. D.(Address) 3375 S. Jefferson Ave

(Licensed Embalmer's Statement on Reverse Side)

n. 2.—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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Benj. C. Duncan*

Licensed Embalmer No. *2272*

P. O. Address *1924 Allen*

**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.**