MAR 13 1939

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

791
1003

Do not use this space. 4849

1. PLACE OF DEATH

(a) County ..... Registration District No. .....

(b) Township or City ..... Primary Registration District No. ..... Registered No. 1542

(c) St. Louis Mo. (d) Street No. City Hospital No 1 St.
(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 Hermina Hrich (Rich) 200

(a) Residence, No. 4967 Tyroleon Ave. St. 2
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Hrich.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 1878

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
About 60			

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. Housework
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) Austria Bohemia

FATHER
13. NAME ? Kretovich
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

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

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17. INFORMANT (ADDRESS) Joseph Hrich 4967 Tyrolean Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE New S.S. Peter & Paul DATE Feb 18, 1939

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

20. FILED FEB 17 1939 J. F. Budeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 1:30 a.m.

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

Chronic Myocarditis

Date of onset

Other contributory causes of importance:

Chronic Interstitial Nephritis

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

What test confirmed diagnosis? ..... Was there an autopsy? No

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? No

If so, specify .....

(Signed) Joseph M. Quinn, M.D.

(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

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.

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

THOS. KUTIS., Registered Apprentice No.

working under my personal supervision.

Signed Thos Kutis

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 comp with the above constitutes grounds for revocation of license.)

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