

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

19641
Do not use this space.

9570 JUN 24 1939

1. PLACE OF DEATH
 (a) County St. Francois Registration District No. 475
 (b) Township Perry Primary Registration District No. 6000-A
 (c) City Bonne Terre (d) Street No. _____ 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 Albert Kuchlik
 (a) Residence, No. Bonne Terre Mo. (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 26, 1881

7. AGE YEARS 57 MONTHS 8 DAYS 0 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Foreman

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 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bonne Terre, Missouri

FATHER 13. NAME Christian Kuchlik

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

MOTHER 15. MAIDEN NAME Maria Glichik

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Mr. Albert Kuchlik, Bonne Terre, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE P. Cemetery DATE May 28, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Benjamin Thiel Co, Bonne Terre, Mo.

20. FILED 5-27-39 N. W. Hawkin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1938, to May 26, 1939
 I last saw him alive on May 26, 1939. Death is said to have occurred on the date stated above, at 9:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Coronary thrombosis (arteriosclerosis), coma, lower extremity paralysis (terminal) Date of onset _____

Other contributory causes of importance: none

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? no
 If so, specify _____ (Signed) A. L. Evans, M. D.
Bonne Terre, Mo. (Address)

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,

A. J. Claywell

....., or by

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

Signed.....

A. J. Claywell

Licensed Embalmer No.....

3706

P. O. Address.....

Bound Brook, N.J.

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.