

JUL 12 1939 **791**

Registration District No. **1008** Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town _____
(c) Name of hospital or institution:
Little Sisters of Poor, 2209 Hebert St.
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 7 yrs. 3
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Conrad Kurnick
3. (b) If veteran, name war No.
3. (c) Social Security No. none

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced W.
6. (b) Name of husband or wife Anna 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 2 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Austria
(City, town, or county) (State or foreign country)

10. Usual occupation Miner
11. Industry or business Coal Industry

12. Name Caspar Kurnick
13. Birthplace Austria
(City, town, or county) (State or foreign country)

14. Maiden name Mary Kipsick
15. Birthplace Austria
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sister Jean
(b) Address 2209 Hebert St.

17. (a) Galvary Burial (b) Date thereof 6-21-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galvary
18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd

19. (a) JUN 21 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis 120
(If outside city or town limits, write "RURAL")
(d) Street No. 2209 Hebert St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. 25 Years years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 20
year 1939 hour 120 minute a. M.
21. I hereby certify that I attended the deceased from January 15, 1939 to June 20, 1939
that I last saw him alive on June 19, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Hyperlophic Bilateral Cerebrosclerosis
Due to _____
Due to _____
Other conditions Galvanization
(Include pregnancy within _____ months of death)
Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? 1 (Specify type of place) _____
(e) Means of injury _____
23. Signature Anthony G. Thekarakis (M. D. or other) _____
Address 1525 a Cass Ave Date signed 6/20/39

WHILE PLAINLY—USE UNFADING BLACK INK—WRITE A PERMANENT RECORD
 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.....

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

working under my personal supervision.

Signed..... *Alfred J. Boedeker*

Licensed Embalmer No. *2663*

P. O. Address. *4204 Prairie*

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.