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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27301

REC'D SEP 14 1939

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 6801

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Anthony Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 Days. (Specify whether

In this community 76 Years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis. (If outside city or town limits, write "RURAL") 22

(d) Street No. 1120 Dillon St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Rose Uxa.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow.

6. (b) Name of husband or wife Charles Uxa.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. 23. 1861 (Month) (Day) (Year)

8. AGE: Years 78. Months 5 Days 8 If less than one day hr. min.

9. Birthplace Jefferson County (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business

FATHER
12. Name Jacob Kristof
13. Birthplace Bohemia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Kratky
15. Birthplace Bohemia. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mamie Uxa.

(b) Address 1120 Dillion St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 7/39 (Month) (Day) (Year)

(c) Place: burial or cremation S. S. Peter & Paul

18. (a) Signature of funeral director Thos Lutis

(b) Address 2906 Gravois Ave.

19. (a) AUG 4 1939 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. 3 day year 1939 hour 1 30 minute PM. M.

21. I hereby certify that I attended the deceased from July 3 - 39, 19, to Aug 3, 1939; that I last saw her alive on Aug 3rd, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chr. Parenchymatous Nephritis	5 yrs
Due to: Fractured Right Hip	1 mo
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

O. K. M. Fried Deputy Coroner 8/4/39

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence July 3 - 39

(c) Where did injury occur? Home (City or town) St. Louis (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury slipped on floor

23. Signature N. M. Friend (M. D. or other)

Address 3115 S Grand Date signed 8/4/39

(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.

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

X19511

Dr. [illegible]
3115 [illegible]
[illegible]
Je [illegible]

11-12.30 -

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

Signed Leo Budde

Licensed Embalmer No. 3989

P.O. Address St. Louis, [illegible]

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.