

WHITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33452

State File No.

Registrar's No. 1725

Registration District No. 784

Primary Registration District No. 101

1. PLACE OF DEATH:

(a) County ST. Louis Co.
 (b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis Co. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 Weeks
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St Louis Co
 (c) City or town Wellston
(If outside city or town limits, write "RURAL")
 (d) Street No. 1639 Vassier Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. 33 years.

3. (a) PRINT FULL NAME

Frank Kordich 6320

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 2-1939 day 2
 year 1939 hour 1.40 minute AM M.

3. (b) If veteran, name war _____

3. (c) Social Security No. 497-05-7454

21. I hereby certify that I attended the deceased from August _____, 1939, to Oct 2, 1939;
 that I last saw him alive on Oct 2, 1939;
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Sophie Kordich 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased July 2 1890
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Liver (Primary) Duration 6 mo.

8. AGE: Years 49 Months 3 Days 0 If less than one day hr. _____ min. _____

Due to _____
 Due to 46

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Laborer

11. Industry or business _____

Major findings: Of operations _____

12. Name Unknown

Of autopsy Carcinomatous - Liver & metastases

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. (a) Informant's own signature Mrs Sophie Kordich

(b) Address 1639 Vassier

17. (a) Burial (b) Date thereof Oct. 4 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Geo L Pleitsch

(b) Address 5966 Easton Ave St Louis Mo.

19. (a) OCT 2 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature Mamie S. Murphy (M. D. or other) M.D.

Address St. Louis County Hospital Date signed 10-2-39

STATEMENT OF OCCUPATION IS A VITAL PART OF THE RECORDS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
EX-111
U.S. GOVERNMENT PRINTING OFFICE: 1967 O - 345-111

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

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FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

33452
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
(b) Township Clayton Primary Registration District No. 101 Registered No. 1728
(c) City..... (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

Frank Hardich
(a) Residence, No. _____ St. (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 3 0

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Danube Austria

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 10-2 1939 J.R. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

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

I last saw him alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

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

Date of onset

Other contributory causes of importance:

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? _____

If so, specify _____

(Signed) Maryann S. Meyer, M. D.

(Address) 1011 S. 1st St. St. Louis, Mo.

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

