

WRITE 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.

Registration District No. 702

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: City Hospital, #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 Days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME John Holba

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Amelia Holba 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 2 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 7 28 hr. min.

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

10. Usual occupation Tailor

11. Industry or business For himself

12. Name John Holba

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Theo. B. Holba  
(b) Address 5463 Geraldine

17. (a) Burial (b) Date thereof 11-2-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director John A. Genteman  
(b) Address 5077 Durant Ave.

19. (a) Oct 31 1939 (b) J. F. Budech  
(If not received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town City of St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5463 Geraldine Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 40 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30,  
year 1939 hour 12:10 minute P. M.

21. I hereby certify that I attended the deceased from October 23, 1939, to October 30, 1939  
that I last saw him alive on October 30, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Intentional obstruction of gall stone

Due to Perforation of gall bladder into pleuroperitoneum

Other conditions Chronic cholecystitis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_  
(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 Marcelle J. Kelly (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette, Date signed 10/30/39

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**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 J. B. Sullivan  
Licensed Embalmer No. 1122

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.**