DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 13 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

38030

State File No.

Registration District No. 791

Primary Registration District No.

Registrar's No. 9869

1. PLACE OF DEATH: 1003
(a) County 1
(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. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 DAYS.
(Specify whether
In this community years, months or days) 2 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 1
(c) City or town ST. LOUIS 11
(If outside city or town limits, write "RURAL")
(d) Street No. 1027 A N. VANDEVENTER
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 32 years.

3. (a) PRINT FULL NAME MILE VUKOVICH
3. (b) If veteran, name war NO
3. (c) Social Security No. NO
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife RUZA VUKOVICH
6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased NOV. (Month) 1 (Day) 1890 (Year)

8. AGE: Years 48 | Months — | Days 16 | If less than one day ___ hr. ___ min.

9. Birthplace SERBIA (City, town, or county) (State or foreign country)
10. Usual occupation PROPRIETOR
11. Industry or business SOFT DRINK PARLOR.
FATHER
12. Name TOM VUKOVICH 7
13. Birthplace SERBIA 7 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name MILICH BOLANOVICH
15. Birthplace SERBIA 7 (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Ruza Vukovich
(b) Address 1027 a N. Vandeventer a
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 20 39 (Month) (Day) (Year)
(c) Place: burial or cremation MT. HOPE CEM.
18. (a) Signature of funeral director E. J. Schmitz
(b) Address 3125 Lafayette Av.
19. (a) NOV 20 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17th year 1939 hour 10 minute 48 P M.
21. I hereby certify that I attended the deceased from November 12th, 1939, to Nov. 17th, 1939; that I last saw him alive on Nov 17th, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal Obstruction	6 days
Due to: Post operation Ventral hernia	5 yrs.
Umbilical Hernia	4 yrs
Due to:	
Other conditions: Diabetes Mellitus + Obesity (Include pregnancy within 3 months of death)	

Major findings: Of operations: Intestine obstructed at neck of hernial sac.
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature C. E. Matlock (M. D. or other) MD
Address 4989 Neosho St Date signed 11/18/39

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39 1 X19511

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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave.

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.