

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 very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7350

Registration District No. 547

Primary Registration District No. 3079

Registrar's No. 73

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St Elizabeth
 (If not in hospital or institution, write street number or location) 1
 (d) Length of stay: In hospital or institution 1DY (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Ralls
 (c) City or town Rural, New Harbor
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Steve Mikulcick 247

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

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

7. Birth date of deceased Feb 11 1919
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>-</u>	<u>7</u>	hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name STEVIE MIKULCICK Sr

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

14. Maiden name Hanna Katsack

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

16. (a) Informant's own signature Anna Mikulcick

(b) Address 1122 New London, MO

17. (a) Burial (b) Date thereof Feb 20-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cemetery

18. (a) Signature of funeral director James O'Connell

(b) Address Hannibal MO 4415

19. (a) 2-26-40 (b) W.C. Gisher
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 18
 year 1940 hour 5 minute 9 M.

21. I hereby certify that I attended the deceased from Feb 18 1940 to Feb 18 1940
 that I last saw him alive on Feb 18 1940
 and that death occurred on the day and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration _____

Due to auto accident coming back of bar

Other conditions Internal injuries
 (Include pregnancy within 3 months of death) Shock

Major findings: Of operations _____

Of autopsy _____

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

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

(b) Date of occurrence Feb 18 1940

(c) Where did injury occur? Spring MO
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? City street

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature John P. Reubens (M.D. or other) MD

Address 1014 1/2 N. Main St. Hannibal MO Date signed 2/26/40

210M
4/10/10

STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES

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 Michael J. Allamee

Licensed Embalmer No. 3246

P. O. Address Humble, TX

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7350

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 547

Primary Registration District No. 3029

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Steve Mikuleis

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

4. Sex m 5. Color or race w

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>-</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Duration _____

Due to: Auto accident

Due to: Collision & pedestrian is struck by car

Other conditions: _____ (Include pregnancy within 3 months of death)

Internal injuries & shock

Major findings: _____

Of operations: _____

Of autopsy: 210 W
21

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 John G. Reichman (Date signed) _____

Address Hannibal Mo Date signed _____

SUPPLEMENTAL

