

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9053

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2536

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:
Missouri Pacific Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME JOHN SUGAR (CUKAR)
 8. (b) If veteran, name war nil
 8. (c) Social Security No. _____

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Milka Sugar
 6. (c) Age of husband or wife if alive 47 years
 7. Birth date of deceased About 1888
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 52 ? ? hr. min.

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

10. Usual occupation Cooper

11. Industry or business Missouri Pacific R.R.

MOTHER FATHER
 { 12. Name Matt Cukar
 { 13. Birthplace Croatia
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Unknown
 { 15. Birthplace Croatia
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Manul
 (b) Address 319 Bennett R. G. K.
 17. (a) Burial (b) Date thereof 3-17-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Kansas City, Kansas

18. (a) Signature of funeral director Sam. C. Mayhew
 (b) Address 1926 Allen Ave.

19. (a) MAR 17 1940 (b) J. B. Sidick
 (Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Kansas (b) County _____
 (c) City or town Kansas City NR
 (If outside city or town limits, write "RURAL")
 (d) Street No. 955 S. Lusk St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 17
 year 1940 hour 8 minute 20 A. M.
 21. I hereby certify that I attended the deceased from March 15, 1940, to March 17, 1940, that I last saw him alive on March 17, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiac failure Duration _____
 Due to Chr. Myocarditis and Chr. Bronchitis
 Due to _____
 Other condition Bronchitis
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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 Malvern T. Bryan (M. D. or other) _____
 Address Missouri Pacific Hosp. Date signed 3/17/40

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.

00146-17-39
 Rev. 5-17-39
 U. S. GOVERNMENT PRINTING OFFICE

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 Benj. C. Duncan
Licensed Embalmer No. 2272
P. O. Address 1926 Allen

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.