

FILED APR 15 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 9374
Registrar's No. 2857

Registration District No. 791

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
EnRoute To City Hospital No 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life (Specify whether
years, months or days)

3. (a) PRINT FULL NAME JOSEPH DUDA

3. (b) If veteran, name war _____ 3. (c) Social Security No. 473-09-5920

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

6. (b) Name of husband or wife Rose Duda 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Aug. 8. 1880
(Month) (Day) (Year)

8. AGE: Years 59 Months 87 Days 17 If less than one day hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Shoe Worker

11. Industry or business Shoe Factory.

12. Name Joseph Duda

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

14. Maiden name Kate Tickwart

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

16. (a) Informant Rose Duda.

(b) Address 4660 Ray Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29/40
(Month) (Day) (Year)

(c) Place: burial or cremation New S.S. Peter & Paul

18. (a) Signature of funeral director Shoemaker

(b) Address 2906 Gravois Ave.

19. (a) MAR 27 1940 (b) J. F. Braddock
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")

(d) Street No. 4660 Ray Ave.
(If rural, give location)

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

NO ATTENDING PHYSICIAN

20. DATE OF DEATH: Month March day 25
year 1940 hour 7 30 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism; Myocardial Infarctis (old); Varicose Veins left leg.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) g.H.B.

Major findings: Of operations _____

Of autopsy _____

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 [Signature] (M. D. or other) _____

Address [Signature] Date signed 3:26.40

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 _____

Thorlute's

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Thorlute's

Licensed Embalmer No. 1619

P. O. Address 2906 Grassie

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.