

No. 2  
11-10-39  
1-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13453

MAY 15 1940

State File No.

3655

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

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: 1437 Chambers  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 yrs. (Specify whether  
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis 26  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1437 Chambers  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Teresa Kardasz 632

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

4. Sex Female 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. June 25 1930  
(Month) (Day) (Year)

8. AGE: Years 9 Months 10 Days 26 If less than one day hr. \_\_\_\_\_ min. 5

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Frank Kardasz 5

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

14. Maiden name Lucille Bialczak

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

16. (a) Informant Pattie Kardasz  
(b) Address 1437 Chambers St.

17. (a) Burial (b) Date thereof April 24  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director St. Louis Funeral Home  
(b) Address 2205 St. Louis Ave.

19. (a) APR 23 1940  
(Date received local registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21  
year 1940 hour 6 minute 15 P M.

21. I hereby certify that I attended the deceased from April 13  
1940 to April 21 1940  
that I last saw her alive on April 20 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis of respiratory system 3 weeks.  
Tuberculosis of meninges and central  
nervous system.

Due to Tubercle bacillus.

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

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

Duration  
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 John H. Bunker (M. D. or other) \_\_\_\_\_  
Address 2767 Genesee Date signed 4-23-40

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

**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

*Albert G. Hoff*

Licensed Embalmer No. 2971

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.**