DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16810

Registration District No. 791 d Primary Registration District No. 1003 Registrar's No. 4288

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: St. Anthony's Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 70 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St. Louis 23 (If outside city or town limits, write "RURAL")

(d) Street No. 1845 S. 11th (If rural, give location)

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

3. (a) PRINT FULL NAME Mitan Gavran

3. (b) If veteran, name war no

3. (c) Social Security No. 492-07-6048

4. Sex male

5. Color or race W.

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

6. (b) Name of husband or wife Julia Gavran

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Oct. (Month) 8 (Day) 1884 (Year)

8. AGE: Years 55 Months 7 Days 6 If less than one day hr. min.

9. Birthplace Austria-Hungary (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Stephen Gavran

13. Birthplace Austria-Hungary (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Unknown

15. Birthplace Austria-Hungary (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Julia Gavran

(b) Address 1845 S. 11th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/40 (Month) (Day) (Year)

(c) Place: burial or cremation Bevo Mill Cemetery

18. (a) Signature of funeral director Chulik Und. Co

(b) Address 1716 S. Jefferson

19. (a) MAY 14 1940 (Date received local registrar) (b) J. W. Chulik (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14th year hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 1st, 1940, to May 14, 1940, that I last saw him alive on May 13, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Primary carcinoma of rt. upper lobe of lung — Duration 8 mo.

Due to

Due to

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy yes at St. Anthony's Hosp.

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

22. If death was due to external causes, fill in the following: no

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

(b) Date of occurrence

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

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 Jno J. Wolfarth M.D. (M. D. or other)

Address 1040 Emmet Date signed 5-14-40

(Licensed Embalmer's Statement on Reverse Side)

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.

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

Form 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 B. W. Finn

Licensed Embalmer No. 1591

P. O. Address Botanical

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.