

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
(d) Street No. 1615 Dolman St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Joseph Kulisek 422

3. (b) If veteran, name war nil 3. (c) Social Security No. 488-10-3843

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

6. (b) Name of husband or wife Julia Kulisek 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased March 10, 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 4 8 hr. min.

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

10. Usual occupation Laborer

11. Industry or business Bell Telephone Co.

12. Name Frank Kulisek

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

14. Maiden name Unknown

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

16. (a) Informant Julia Kulisek

(b) Address 1615 Dolman St.

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

(c) Place: burial or cremation Old SS. Peter & Paul

18. (a) Signature of funeral director Wm C Moydel
(b) Address 1926 Allen Ave.

19. (a) JUL 18 1940 (b) J. F. Bredeck
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18,
year 1940 hour 3:45 minute A. M.

21. I hereby certify that I attended the deceased from July
9, 1940 to July 18, 1940;
that I last saw h. im alive on July 18, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Peritonitis (post-operative)
Acute Pancreatitis
Due to Operation - cholecystitis
no stones

Due to _____
Other conditions
(Include pregnancy within 3 months of death)
127

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 Wm A. Elliott (M. D. or other) _____
Address 1515 Lafayette Date signed 7/18/40

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.....

Licensed Embalmer No.....

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.