

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26593**
Registrar's No. **6489**

FILED SEP 25 1940

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis/**
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution: **City Infirmary.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **August 12, 1937**
50yrs. (Specify whether years, months or days)

In this community:
3. (a) PRINT FULL NAME **John Preksatis** **672**
3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Unknown.** 6. (c) Age of husband or wife if alive **unk** years
7. Birth date of deceased **unknown 1867**
(Month) (Day) (Year)

8. AGE: Years **66** Months **1** Days **23** If less than one day hr. min.

9. Birthplace **Russia** **Foreigner**
(City, town, or county) (State or foreign country)

10. Usual occupation **No Occupation**

11. Industry or business **Unknown** **9**

MOTHER FATHER { 12. Name **"** **"**
18. Birthplace (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **"** **"**
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **E. Moloney**
(b) Address **5800 Arsenal St.**

17. (a) **removal** (Burial, cremation, or removal) (b) Date thereof **Aug 1 - 1940**
(Month) (Day) (Year)
(c) Place: burial or cremation **Collinsville, Ill**

18. (a) Signature of funeral director **Derby H. Rasmussen**
(b) Address **315 Vandavia St. Collinsville, Ill**

19. (a) **AUG 1 1940** (Date received local registrar) (b) **J. F. Briedeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis.**
(c) City or town **St. Louis,** **13**
(If outside city or town limits, write "RURAL")
(d) Street No. **5800 Arsenal St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **Foreigner.** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month **July** day **31.**
year **1940** hour **4:15** minute **p.** M.

21. I hereby certify that I attended the deceased from **August 12,** 19**37**, to **July 31,** 19**40**,
that I last saw him alive on **July 31,** 19**40**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Regenerative Heart Disease**
Duration

Due to **arteriosclerosis**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **92**
Of autopsy **M**
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?

While at work? (Specify type of place) Means of injury

23. Signature **W. S. Galis** (M. D. or other)
Address Date signed

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.

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

L.R. Casper

Licensed Embalmer No. *8633*

P. O. Address *2317 Lafayette*

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.