

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7353**

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

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:
3400 S. Grand Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME **JOHN KOZEL**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

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

6. (b) Name of husband or wife **Josephine** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 25, 1857**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 **1** **6** hr. min.

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

10. Usual occupation **None**

11. Industry or business _____

MOTHER FATHER { 12. Name **Michael Kozel**

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

14. Maiden name **Barbara Fuerst**

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

16. (a) Informant **Emil Kozel**

(b) Address **2037 Allen Ave.**

17. (a) **Burial** (b) Date thereof **Sept. 4-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **J. H. Maydell**

(b) Address **1926 Allen Ave.**

19. **SEP 2 1940** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **16**
(If outside city or town limit, write "RURAL")
(d) Street No. **3400 S. Grand Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **1**
year **1940** hour **6** minute **40 P. M.**

21. I hereby certify that I attended the deceased from **Aug. 28**, 19**40** to **Sept. 12**, 19**40**,
that I last saw **him** alive on **Aug. 31**, 19**40**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **4 days**

Due to **Arterio-sclerosis** **2 yrs.**

Due to _____

Other conditions **Senility**
(Include pregnancy within 3 months of death)

Major findings: **g 2001**
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? _____

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

23. Signature **J. H. Maydell M.D.** (M. D. or other) **1**
Address **439 Bate** Date signed **9/7/40**

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..... *Benj. C. Dumas*

Licensed Embalmer No. *2272*

P. O. Address *1226 Allen*

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.