

Rev. 6-17-39  
I-10151

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

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.

Registered District No. **FILED OCT 23 1940**

Primary Registration District No. **4465**

1. PLACE OF DEATH: **St. Francois**  
(a) County **St. Francois**  
(b) City or town **FLAT RIVER MO**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2**  
In this community **30 yrs**  
years, months or days (Specify whether)

8. (a) PRINT FULL NAME **BALAZS HARGO**  
8. (b) If veteran, name war **—**  
8. (c) Social Security No. **—**

4. Sex **M**  
5. Color or race **W**  
6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive **—** years  
7. Birth date of deceased **Oct 10 1886**  
(Month) (Day) (Year)

8. AGE: Years **88** Months **11** Days **3**  
If less than one day **—** hr. **—** min.

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

10. Usual occupation **House work**

11. Industry or business **—**

MOTHER FATHER { 12. Name **not known**  
13. Birthplace **Hungary**  
(City, town, or county) (State or foreign country)  
14. Maiden name **not known**  
15. Birthplace **Hungary**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Julia Lang**  
(b) Address **Madison Sts**

17. (a) **Burial** (b) Date thereof **9-16-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **St. Francois Mo**

18. (a) Signature of funeral director **Jos Diemer**  
(b) Address **Flat River Mo**

19. (a) **9/14/40** (b) **CB Pearson**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Francois**  
(c) City or town **Flat River Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **—**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? **35** year

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept** day **13**  
year **1940** hour **3** minute **P.**  
21. I hereby certify that I attended the deceased from **9-9-40**  
to **9-13**, 19**40**  
that I last saw him alive on **9-13-40**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **acute Dilatation of Heart**  
Due to **Chronic Myocarditis**  
Due to **Chronic Myocarditis**  
**arterial sclerosis**  
Other conditions **—**  
(Include pregnancy within 3 months of death)  
Major findings: **—**  
Of operations **—**  
Of autopsy **—**

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 **Paul Z. Jones** (M. D. or other)  
Address **Flat River, Mo** Date signed **9-14-40**

Duration **24 hrs**  
Smoked **—**  
Lived **—**  
Lived **—**  
Lived **—**  
PHYSICIAN **—**  
Underline the cause which death should be charged statistically.

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**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 Joseph Diemer  
Licensed Embalmer No. 970  
P. O. Address Flat River Mo

**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.**