

791 |
NOV 16 1940
Registration District No.

1003
Primary Registration District No.

8156

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:
Missouri Pacific Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ 21 yrs (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St Jennings N/R
(If outside city or town limit write "RURAL")
(d) Street No. 5740 Annae Ave.
(If rural, give location)
(e) Foreign born or long in U. S. A? _____ 40 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29
56 year 1940 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
hemorrhage (non traumatic)
supernecrotic splenitis
Due to infectious
Due to _____

Duration

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
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. B. Braddock (M. D. or other) _____
Address _____ Date signed _____

3. (a) PRINT FULL NAME JOSEPH L. KOVIK
3. (b) If veteran, name war NONE 3. (c) Social Security No. 702-12-4756

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Koviak 6. (c) Age of husband or wife if alive 45 2 years
7. Birth date of deceased 9-27-1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 0 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Poland 7
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter 7

11. Industry or business Railroad TERMINAL 7

MOTHER FATHER { 12. Name John Koviak 1
13. Birthplace Poland (City, town, or county) (State or foreign country)
14. Maiden name Antonette (City, town, or county) (State or foreign country)
15. Birthplace Poland (City, town, or county) (State or foreign country)

16. (a) Informant Mary Koviak
(b) Address 5740 Annae Ave

17. (a) Burial (b) Date thereof 10-2-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director J. B. Braddock
(b) Address 2117 E. Grand Blvd.

19. (a) OCT 1 1940 (b) J. B. Braddock
(Date received local registrar) (Registrar's signature)

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

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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 Frank A. Morris
Licensed Embalmer No. 3041
P. O. Address 2117 E. Grand

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.