

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis, Mo.  
(c) Name of hospital or institution: City Hospital #1  
(d) Length of stay: In hospital or institution.....  
In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....  
(c) City or town St. Louis  
(d) Street No. 1800 Menard Street  
M. Attending Physician  
If foreign born, how long in U. S. .... years.

3. (a) PRINT FULL NAME Sam Sinovich

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased About 1877  
(Month) (Day) (Year)

8. AGE: Years About 63 Months Days If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business 7

12. Name Nikola Sinovich 7

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

14. Maiden name Unknown

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

16. (a) Informant Joseph Breich

(b) Address 7802 Gravois Avenue

17. (a) Burial (b) Date thereof Dec. 27, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park

18. (a) Signature of funeral director Wm. C. Snyder

(b) Address 226 Allen Avenue

19. (a) DEC 26 1940 (b) J. T. Brudack  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 23rd  
year 1940 hour 10:30 minute AM

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Peritonitis due to gastric ulcer  
Bilateral Hippostatic pneumonia, unspecified

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: 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 Thomas F. Callahan (M. D. or other) 5  
Address Deputy Coroner Date signed 12/20/40

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

MOTHER FATHER

**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. Duncan*

Licensed Embalmer No. *2272*

P. O. Address *1926 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, fact should be so stated above.**