

2  
-1-4-41  
-17-39  
X26330

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15796

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1051

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution ROBERT KOCH HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 381 days  
(Specify whether  
In this community 18 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4129 DONOVAN  
(If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country 1

3. (a) PRINT FULL NAME

FRANK KELEMEN

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 17  
year 1941 hour 4 minute 00 A. M.

21. I hereby certify that I attended the deceased from MAY 1 1940 to MAY 17 1941  
that I last saw him alive on MAY 17 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY TUBERCULOSIS

Due to 13 B.

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?

(Specify type of place) while at work?  
(e) Means of injury.  
23. Signature Robert Koch Hospital (M. D. or other)  
Address Robert Koch Hospital Date signed 5/17/41

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife AMERENCIA KELEMEN 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased OCTOBER 18, 1882  
(Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days 29  
If less than one day hr. min.

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

10. Usual occupation MECHANIC

11. Industry or business

12. Name ALEXANDER KELEMEN

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

14. Maiden name THERESA PALANKY

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

16. (a) Informant KOCH RECORDS

(b) Address

17. (a) Burial (b) Date thereof 5-20-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter's Bur.

18. (a) Signature of funeral director Theresa Kelemen

(b) Address 4129 Donovan  
(c) Date received local registrar MAY 19 1941  
(d) Registrar's signature Robert Koch Hospital

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

6  
0  
0

**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 *Edwin M. Hermit*

Licensed Embalmer No. *3024*

P. O. Address.....

**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.**