

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **St. Louis Mo.**  
(b) City or town **St. Louis Mo.**  
(c) Name of hospital or institution **St. Anthony Hospital**  
(d) Length of stay: In hospital or institution **5 Days.**  
In this community **Life.**

3. (a) PRINT FULL NAME **ROBERT MULAC**  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. **489-09-4225**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
(b) Name of husband or wife **Cleo. Mulac.** (c) Age of husband or wife if alive **31** years  
7. Birth date of deceased **July 25 1910**

8. AGE: Years **35** Months **9** Days **25** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **St. Louis Mo.**

10. Usual occupation **Sheet Metal Worker**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **William Mulac**  
13. Birthplace **Bohemia**  
14. Maiden name **Magdelene Tringl**  
15. Birthplace **St. Louis Mo.**

16. (a) Informant **Cleo Mulac**  
(b) Address **3641 Virginia Ave.**

17. (a) **Burial** (b) Date thereof **May 22/41**  
(c) Place: burial or cremation **S.S.; PETER & PAUL**

18. (a) Signature of funeral director **Thos. Curtis & Son**  
(b) Address **2906 Gavois Ave.**

19. (a) **MAY 21 1941** (b) **J.P. Brudeck**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MISSOURI** (b) County **000**  
(c) City or town **ST. LOUIS.** (If outside city or town limits, write "RURAL") **1617**  
(d) Street No. **3641 VIRGINIA AVE.** (If rural, give location) **9**  
(e) If foreign born, how long in U. S. A.? **LIFE.** years **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **19** year **1941** hour **4 45 P.M.** minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from **5-15-41** to **5-19/41**  
that I last saw **him** alive on **5-19** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Peritonitis** Duration **5 days**

Due to **Acute Appendicitis** **1 week**

Due to \_\_\_\_\_

Other conditions **1st 2nd 3rd**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **Acute Appendicitis**  
**Acute Peritonitis**  
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 **S.A. Pester** (M. D. or other) **D**  
Address **439 Bates** Date signed **5/20/41**

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

1900  
1900  
1900

Dr. Nestler  
Margaret P. Bates

**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.....

*Thos Luttis*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Thos Luttis*

Licensed Embalmer No. *1619*

P. O. Address *2406 Gavo*

**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.**