

No. 2
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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6905

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3639 Minnesota Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Life. (Specify whether years, months or days)

3. (a) PRINT FULL NAME FRANK SUDA.

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 Widower

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

7. Birth date of deceased June 14 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>71</u>		<u>2</u>	<u>11</u>	hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Hardware Dealer

11. Industry or business _____

12. Name Frank Suda

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

14. Maiden name Anna Cervenka

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

16. (a) Informant Anna Suda

(b) Address 3639 Minnesota Ave.

17. (a) Burial (b) Date thereof Aug 27/4
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S.S. Peter & Paul

18. (a) Signature of funeral director Thorkutis & son
(b) Address 2906 Gravois Ave.

19. (a) AUG 26 1941 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis. 1716
(If outside city or town limits, write "RURAL")
(d) Street No. 36 39 Minnesota Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? Life 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25 year 1941 hour 6 05 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Jan. 1941 to Aug. 25 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to arterio sclerosis

Due to _____

Other condition chronic nephritis
(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 [Signature] (M. D. or other) _____
Address 2901 [Address] Date signed 8-25-41

Duration 2 1/2 hours
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

David Milton Van Fossen

Registered Apprentice No. *280*

working under my personal supervision.

Signed *Thos Curtis*

Licensed Embalmer No. *1619*

P. O. Address *2906 Graves*

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.