

STANDARD CERTIFICATE OF DEATH

State File No. 31192

FILED SEP 26 1941

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 222

1. PLACE OF DEATH: Calloway  
 (a) County Calloway  
 (b) City or town Fulton Co. Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital no 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 mo, 19 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph Imry  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 12K

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Barbara Imry 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 13 1876  
 (Month) (Day) (Year)

8. AGE: Years 65 Months 7 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Baker

11. Industry or business \_\_\_\_\_  
 { 12. Name U.K.  
 13. Birthplace U.K. (City, town, or county) (State or foreign country)  
 14. Maiden name U.K.  
 15. Birthplace U.K. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Barbara Imry

(b) Address 1362 Hodiamont av. St Louis

17. (a) Termination (b) Date thereof 8-22-1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director E. L. Pleutsch D.D.  
 (b) Address 5966-68 Eastern Ave. St Louis Mo.

19. (a) 8/19/41 (b) R. N. Crews  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO (b) County St Louis  
 (c) City or town St. Louis Mo (If outside city or town limits, write "RURAL")  
 (d) Street No. 1362 Hodiamont av. (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 34 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19 year 1941 hour 7 minute 40 A.M.

21. I hereby certify that I attended the deceased from Aug 1-4, 1941, to Aug 19, 1941; that I last saw him alive on Aug 18, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Dilated atherosclerosis (general) & Syphilitic meningitis encephalitis

Other conditions (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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
 While at work? (e) Means of injury \_\_\_\_\_

23. Signature James Thorne (M. D. or other) \_\_\_\_\_  
 Address State Hospital no 1 Date signed 8/19-41

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

**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.....

*Leonard W. Kraeger*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Leonard W. Kraeger*.....  
Licensed Embalmer No. *2678*.....

P. O. Address *St. Louis, Mo.*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Callaway  
 (b) City or town Fulton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution State Hosp No 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 mo 19 days (Specify whether  
 In this community 4 mo 19 days years, months or days)

3. (a) PRINT FULL NAME Joseph Imry  
 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 married  
 6. (b) Name of husband or wife Barbara Imry Age of husband or wife if ok years  
 7. Birth date of deceased Jan 13, 1876 (Month) (Day) (Year)

8. AGE: Years 65 Months 7 Days 14 (If less than one day \_\_\_\_\_) min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Aug 9, 1941 (b) R. N. Crewe (Date received local registrar) (Registrar's signature)  
Nov. 3, 1941.

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day \_\_\_\_\_ Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941

S-31192