

FILED APR 19 1943 318

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2908 Caroline Str.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME John Sokolic

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

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

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

7. Birth date of deceased February 16 1930
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
13 I 25 ..hr.min.

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

10. Usual occupation At School

11. Industry or business.....

MOTHER FATHER { 12. Name Joseph Sokolic
13. Birthplace Croatia
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Shuta
15. Birthplace Croatia
(City, town, or county) (State or foreign country)

16. (a) Informant Katherine Sokolic
(b) Address 2908 Caroline Str.

17. (a) Burial (b) Date thereof 4/3/43
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Wm E. Magall

(b) Address 1926 Allen Av.

19. (a) APR 2 1943 (Date received local registrar) J. F. Braden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day I
year 1943 hour 3 minute 15 A. M.

21. I hereby certify that I attended the deceased from .., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death acute meningococcal meningitis

Due to.....
Due to.....

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) (c) Means of injury.....

23. Signature Arthur Perry (M. D. or other) Perry
Address..... Date signed 4/4/43

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 allen ave

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.