

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(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:
Isolation Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
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. 1213 Souldard St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Anna Feranec

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John Feranec 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased August 20 1892
(Month) (Day) (Year)

8. AGE: Years 50 Months 10 Days 19 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business George Cibulka

12. Name George Cibulka
13. Birthplace Czechoslovakia
(City, town, or county) (State or foreign country)
14. Maiden name ???
15. Birthplace Czechoslovakia
(City, town, or county) (State or foreign country)

16. (a) Informant John Feranec
(b) Address 1213 Souldard St.

17. (a) Burial (b) Date thereof 7-13-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Concordia

18. (a) Signature of funeral director John G. Maxwell
(b) Address 1926 Allen Ave.

19. (a) 2011 11 1943 (b) J. J. Bulech
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1943 hour 4 minute 50 P.M.
21. I hereby certify that I attended the deceased from 6-27-43
19... to 7-9-43 19...
that I last saw her alive on 7-9-43 19...
and that death occurred on the date and hour stated above.

Immediate cause of death
Cholelithiasis
Cholecystitis
Paratyphoid B. infection

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 Theo. H. Hansen (M. D. or other) W.D.
Address 3651 Grand Ave Date signed 7/10/43

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 Wm. B. Moydell
Licensed Embalmer No. 1467
P. O. Address 1924 Allen

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 6285

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town _____
(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 few hours
(Specify whether _____)

In this community _____
years, months or days
3. (a) PRINT FULL NAME Anna Franca
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____ min.

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) 7/9/43 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

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 _____

20. DATE OF DEATH: July 9th
Month _____ day _____
year _____ hour _____ minute _____ M.

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

Immediate cause of death: Cholerae typhosa
Due to _____
Due to _____

Other conditions: 12/6
(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 _____

SUPPLEMENTARY

Duration _____
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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