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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 21 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29984**
Registrar's No. **8064**

Registration District No. **318**

Primary Registration District No. **1003**

49
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2753 Allen Ave. /
(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

3. (a) PRINT FULL NAME **Peter Hajdin**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color of race **Wht.** 6. (a) Single, widowed, married, divorced **Widower**
6. (b) Name of husband or wife **Catherine Hajdin** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Unknown About 1882**
(Month) (Day) (Year)

8. AGE: Years' Months Days If less than one day
About 61 Unknown hr. min.

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

10. Usual occupation **Stone Mason Retired**

11. Industry or business _____
12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Zora Klein**
(b) Address **Appleton Wis.**

17. (a) **Burial** (b) Date thereof **9/11/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **W. C. Moyall**
(b) Address **1926 Allen Ave.**

19. (a) **SEP 10 1943** (b) **J. H. Hrubek**
(Date received local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000 17**
(c) City or town **St. Louis,** **9 22**
(If outside city or town limits, write "RURAL")
(d) Street No. **2753 Allen Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **Sept.**
year **1943** hour **6⁴⁰** minute **A.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 _____ Duration _____

Chronic Myocarditis
Chronic Interstitial Nephritis
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations **131**
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 **3**
23. Signature **Thomas J. Callahan** (M. D. or other)
Address **Deputy Coroner** Date signed **9-11-43**

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 A. M. Dwyer

Licensed Embalmer No. 3741

P. O. Address 1926 Allen av

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.