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No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 6 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 124

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Summit 1
(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 St. Francois

(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")

(d) Street No. Summit 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MICHAEL VARGO SR.

3. (b) If veteran, name war V

3. (c) Social Security No. V

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Barbara Vargo

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

7. Birth date of deceased Oct 15 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

81 0 5 hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER

12. Name Michael Vargo

13. Birthplace Czechoslovakia

14. Maiden name Anna Kohut

15. Birthplace Czechoslovakia

16. (a) Informant Agnes Vargo

(b) Address Summit St. Bonne Terre

17. (a) Burial (b) Date thereof 10-21-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph's Cemetery

18. (a) Signature of funeral director Barbara Vargo

(b) Address 319 Benham Bonne Terre

19. (a) Oct. 30, 1943 (b) Byndie Burkmaster
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19th
year 1943 hour 7 minute 58 P.M.

21. I hereby certify that I attended the deceased from June 20th
1943, to Oct 19, 1943
that I last saw him alive on Oct 19, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure
Arteriosclerotic heart
Disease
Generalized Arteriosclerosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 92d

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 J. Alelebin M.D. (M.D. or other)
Address Bonne Terre, Mo. Date signed 10-22-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

NOV 24 1948

District Health Officer No. 4
District File Number 1143-2862
Date Filed 11-5-48

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed Clarence J. Claywell

Licensed Embalmer No. 3786

P. O. Address Bonne Sue M

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.