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S. No. 2
M-2-43
5-17-39
PI X35657

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 15 1944
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **11974**

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: **St. Louis City Hosp
Max C. Starkloff Memorial**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 Days**
In this community **50 years** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Regina Soukup**
3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife **late John Soukup** 6. (c) Age of husband or wife if alive **26** years
7. Birth date of deceased **Oct. 26 1866**
(Month) (Day) (Year)

8. AGE: Years **77** Months **2** Days **5** If less than one day _____ br. _____ min.

9. Birthplace **Austria** **Hungary** 4
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____
12. Name **Peter Krip**
13. Birthplace **Austria** **Hungary** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Adam Soukup**
(b) Address **3240 Knapp St**

17. (a) **Burial** (b) Date thereof **1-2-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Doniphan, Mo.**

18. (a) Signature of funeral director **Hv. Leidner U. Co.**
(b) Address **2223 St. Louis Ave.**

19. (a) **DEC 31 1943** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000
17**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **3240 Knapp St.** **926**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **30**,
year **1943** hour **2:00** minute **P.** M.
21. I hereby certify that I attended the deceased from **December**
25, 19 **43** to **December 30**, 19 **43**
that I last saw her alive on **December 30**, 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertensive Heart Disease
Due to... **Cerebral Hemorrhage**
Due to... **with Left Hemiplegia**
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **None**

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) **NO**
(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 **William J. Park** (M. D. or other)
Address **1515 Lafayette Avenue** **12/30/43**

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2423 St. Louis 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.