

No. 2
5-43
17-39
X36971

FILED JAN 12 1944

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **49**

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:
3821 Humphrey St. /
(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 **000
17**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **3821 Humphrey St.** **9**
(If rural, give location) **16**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Tony Muich**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Wid.**
6. (b) Name of husband or wife **Dora** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Unknown About 1870**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 74 Unknown -----
hr. min.

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

10. Usual occupation **Laborer**

11. Industry or business.....

12. Name **Joseph Muich**

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

14. Maiden name **Marie Lisac**

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

16. (a) Informant **Anna Kristanic**

(b) Address **3821 Humphrey St.**

17. (a) **Burial** (b) Date thereof **1/5/44**
(Month) (Year)

(c) Place of burial or cremation **St. Louis Ill.-Mt. Carmel, Belmont**

18. (a) Signature of funeral director **Wm. E. Moydell**

(b) Address **1926 Allen Ave.**

19. (a) **JAN 4 1944** (b) **J. F. Bredes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **Second**
year **1944** hour **2** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Nov 25 1944**
Jan 2 1944
that I last saw him alive on **Jan 1**
and that death occurred on the date and hour stated above.

Immediate cause of death:
**Cordeae Drompex
non
myocardialis
Arterio Sclerosis**

Due to.....
Due to.....
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 **D. J. Jackson** (M. D. or other) **1/3/44**
Address **3115 S. Grand** Date signed **Jan**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 me

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

Signed

A. 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.