

S. No. 2  
DM-5-43  
v. 5-17-39  
P. 1 X36671

FILED SEP 30 1944

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8027

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:  
St Johns 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

3. (a) PRINT FULL NAME John Gazdik

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 0

5. Color or race W

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Pauline Gazdik

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased 1 / 15 / 1886  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>8</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation Coal Miner

11. Industry or business \_\_\_\_\_

12. Name John Gazdik

13. Birthplace Austria 4  
(City, town, or county) (State or foreign country)

14. Maiden name Dont know

15. Birthplace Austria 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Pauline Gazdik

(b) Address Gillespie, Ill.

17. (a) Burial (b) Date thereof 9-21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gillespie, Ill.

18. (a) Signature of funeral director Provost Und Co

(b) Address 3710 N Grand St Louis MO

19. (a) SEP 19 1944 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County 999 NR

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

(d) Street No. Rural  
(If rural, give location)

(e) Citizen of foreign country? 2- (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18  
year 1944 hour 12:40 PM/minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from August 1st  
1944 to Sept 18 1944  
that I last saw him alive on Sept 18 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Branchogenic carcinoma  
of R.A. Lung lobe

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(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 DA Munnich (M. D. or other) \_\_\_\_\_  
Address 529 N Grand Date signed 9/19/44

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

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**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

*Robert R. Brinkman*

Licensed Embalmer No.

*3553*

P. O. Address

*3710 N. Grand*

**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.**