

S. No. 2
M-543
v. 5-17-39
I X36671

29840

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 18 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7684

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Hosp #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

In this community 0 years, months or days

3. (a) PRINT FULL NAME John Ragala

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 Widowed

6. (b) Name of husband or wife _____

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

7. Birth date of deceased act 1874
(Month) (Day) (Year)

8. AGE: Years act 70 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation ret

11. Industry or business _____

MOTHER FATHER

12. Name not known

13. Birthplace not known
(City, town, or county) (State or foreign country)

14. Maiden name not known

15. Birthplace not known
(City, town, or county) (State or foreign country)

16. (a) Informant James J. Fitzgibbon

(b) Address 1300 Clady St

17. (a) (Burial, cremation, or removal) Washington (b) Date of removal 7-44
(Month) (Day) (Year)

(c) Place of burial or cremation Washington

18. (a) Signature of funeral director W. R. Rinkler

(b) Address 3500 Rutledge

19. (a) SEP 6 1944 (b) W. R. Rinkler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1033 Allen Ave
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1944 hour 5 minute 15 P.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 Chronic Myocarditis
Arteriosclerosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93

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) Means of injury _____

23. Signature Alfred Perry (M. D. or other) _____

Address Deputy Coroner Date signed 8/19/44

7687

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.....

Licensed Embalmer No.....

P. O. Address.....

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.