

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(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. Louis City Hospital-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 0 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 009  
(c) City or town ST. LOUIS 17  
(If outside city or town limits, write "RURAL")  
Street No. 2709 INDIANA AVE 923  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME

Julia Hevzy

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife JOHN 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased: JUNE 18 1871  
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 11 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: \_\_\_\_\_ (City, town, or county) HUNGARY (State or foreign country)

10. Usual occupation AT HOME

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

MOTHER FATHER

12. Name KUSZKO  
13. Birthplace HUNGARY  
(City, town, or county) (State or foreign country)  
14. Maiden name DONT KNOW  
15. Birthplace HUNGARY  
(City, town, or county) (State or foreign country)

16. (a) Informant George Lafason

(b) Address 1309 St. Louis Ave

17. (a) BURIAL (b) Date thereof Nov. 2, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lafayette Park Cem.

18. (a) Signature of funeral director John H. Katten Sons

(b) Address 2630 Broadway Ave

19. (a) OCT 31 1944 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th  
year 1944 hour 10:30 minute P. M.

21. I hereby certify that I attended the deceased from 10/23/44  
\_\_\_\_\_, 19\_\_\_\_, to Oct. 29th, 19\_\_\_\_  
that I last saw her alive on Oct. 29th, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 week

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

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy same

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 0

23. Signature Dr. O. Lemay Jr. (M. D. or other) 10/30/44  
Address 1515 Lafayette Date signed \_\_\_\_\_

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

0  
17  
9

**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 Herman A. Sebkun

Licensed Embalmer No. 2120

P. O. Address 2636 / Illinois

**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.**