

No. 2
 8-43
 5-17-39
 X37823

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **39534**
10688
 Registrar's No.

FILED DEC 29 1944
 518

Registration District No. _____ Primary Registration District No. **1003**

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: **Barnes Hospital,**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **18 days** (Specify whether
 In this community **0** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
Illinois **Madison 999**
 (a) State _____
 (b) City or town **Granite City**
 (If outside city or town limits, write "RURAL")
 (c) Street No. **1428 Washington**
 (If rural, give location)
 (d) Citizen of foreign country? _____ (Yes or No)
 If yes, name country **2**

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **December** day **14**th
 year **1944** hour **10** minute **20** P. M.

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
 (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **September 14 1925**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **November 27** 1944 to **December 14** 1944;
 that I last saw him alive on **December 14** 1944 and that death occurred on the date and hour stated above.

8. AGE: **19** Years **30** Months **0** Days If less than one day
 hr. _____ min. _____

Immediate cause of death **ACUTE PULMONARY EDEMA**
 Due to **RENAL INSUFFICIENCY**

9. Birthplace **Granite city Illinois**
 (City, town, or county) (State or foreign country)

Due to **SULFONAMIDE REACTION**

10. Usual occupation **school**

Other conditions **SEPTICEMIA - EMPYEMA**
 (Include pregnancy within 3 months of death)

11. Industry or business _____
 12. Name **John Kulick**
 13. Birthplace **Poland** (State or foreign country)
 14. Maiden name **Eva Mikolajckick** (City, town, or county) (State or foreign country)
 15. Birthplace **poland** (City, town, or county) (State or foreign country)

Major findings: **HO a**
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Anna Kulick**
 (b) Address **Granite City, Ill.**
 17. (a) **rem. to Madison** Date thereof **12-15-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director **Lahey F. Home**
 (b) Address **Madison, Ill.**

While at work? _____ (Specify type of place)
 (e) Means of injury _____

19. (a) **DEC 15 1944**
 (Date received local registrar's certificate)
J. F. Brudeck (Registrar's signature)

23. Signature **FR Bradley** (M. D. or other)
 Address **Barnes Hospital** Date signed **12/15/44**

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

MOTHER FATHER

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 *Ronald O Yaboke*

Licensed Embalmer No. *3917*

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.