

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **623**

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. Louis City Hospital-Max C. Starkoff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

In this community 0
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

Street No. 1812 COLEMAN
(If rural, give location)

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

3. (a) PRINT FULL NAME John Deak

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife BIRDIE

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased MARCH 12 1893
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19th
year 1945 hour 12:55 minute A. M.

21. I hereby certify that I attended the deceased from 1/12/45
19____ to 1/19/45 19____

that I last saw him alive on 1/19/45 19____
and that death occurred on the date and hour stated above.

8. AGE: Years 51 Months 10 Days 7
If less than one day _____ hr. _____ min.

Immediate cause of death Bronchial pneumonia
Duration _____

Due to 107

Due to _____

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

Other conditions Pernicious anemia
(Include pregnancy within 3 months of death)
Cystitis-catarrhal

10. Usual occupation CONTRACTOR

PHYSICIAN _____

11. Industry or business SELF

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 John D. Deak

(b) Address 1812 Coleman

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 1-19-45
(Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director A. Know L. G. Co

(b) Address 2707 N. GRAND BLVD

19. (a) JAN 22 1945 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____

Of autopsy Pernicious anemia
Cystitis

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 M. Hara (M. D. or other) 0
Address 1515 Lafayette Date signed 1/19/45

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

SEP 2 01950

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..... *W E Morris*

Licensed Embalmer No. *3360*

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.