

FILED FEB 24 1945

1003

Registration District No.

Primary Registration District No.

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: Isolation Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 11/18/44 to 2/10/45
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town ST. Louis, MO.
(If outside city or town limits, write "RURAL") 13
(d) Street No. 5800 Arsenal ST
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mildred Cujic

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 George Cujic 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased April 28 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace YugoSlavia (City, town, or county) (State or foreign country) 0

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Vudadihors (Michael)
13. Birthplace YugoSlavia (City, town, or county) (State or foreign country) X
14. Maiden name Perka?
15. Birthplace Yugadihors (City, town, or county) (State or foreign country) 0

16. (a) Informant Viola Becktame
(b) Address 5600 Arsenal ST.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45
(Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Chulick Ltd. Co.
(b) Address 1722 S. Jefferson Ave.

19. (a) FEB 13 1945 (Date received local Registrar) J. F. Brudick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 10
year 1945 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from 11/18/44 to 2/10/45
that I last saw her alive on 2/10/45
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature R. M. Maxwell (M. D. or other) 0
Address 5600 Arsenal St Date signed 2-11-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *Alex. C. Chubb Jr.*

Licensed Embalmer No..... *4143*

P. O. Address..... *1722 S. Jeff*

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.