

FILED FEB 16 1945

State File No. _____

Registration District No. **318**

Primary Registration District No. **1005**

Registrar's No. **1010**

1. PLACE OF DEATH:

(a) County _____
(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 Hospital**
Starkloff Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Paul Kakta**

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 **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased **February 8th 1900**
(Month) (Day) (Year)

8. AGE: Years **44** Months **11** Days **21** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **laborer**

11. Industry or business _____

12. Name **George Kakta**

13. Birthplace **Europe**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

15. Birthplace **Europe**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Kakta**

(b) Address **4709 Hamburg Ave.**

17. (a) **Burial** (b) Date thereof **Feb 1 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **John S. Ziegenheim & Son**

(b) Address **7027 Gravois Ave.**

19. (a) **FEB 1 1945** (b) **J. F. Branch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **716 Walnut St. (Annex Hotel)**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **29th**
year **1945** hour **4:00** minute **57** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Abdominal
of Jejunum by Fibrous band
of some Indocordite at Umbilical
and Aortic valve afferent**
Due to _____

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

Major findings: **92**
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? _____

23. Signature **W. J. Perry** (Specify type of place) _____
Address _____ (M. D. or other) _____
Date signed **2/1/45**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Sheldon Collier*

Licensed Embalmer No. *3382*

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.