

S. No. 2
DM-2.43
5-17-39
L.D. SEP 1 1945 318

25709

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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. 7410

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. Johns Hosp
(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 FRANK GYORGY

3. (b) If veteran, name war No 3. (c) Social Security No. 493 10 8490

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Aug 26 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 11 27 hr. min.

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

10. Usual occupation Shop Work

11. Industry or business Public Service Co

MOTHER FATHER {
12. Name Joseph Gyorgy
13. Birthplace Austria Hungary
(City, town, or county) (State or foreign country)
14. Maiden name Mary Gyocki
15. Birthplace Austria Hungary
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Gyorgy
(b) Address 3830 Blaine Ave

17. (a) Burial (b) Date thereof 8 27 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter Paul

18. (a) Signature of funeral director Kriegshauser

(b) Address 4228 So. Kingshighway

19. (a) AUG 26 1945 (b) J.F. Bredbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17 17
(d) Street No. 3830 Blaine Ave
(If rural, give location) 9
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23
year 1945 hour 6.15 PM minute _____ M.

21. I hereby certify that I attended the deceased from June 11 1945 to 8 - 23 1945
that I last saw him alive on 8 - 23 - 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema

Due to _____
Due to _____

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

Major findings: Of operations 93
Of autopsy _____

Duration
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) _____ (e) Means of injury 0

23. Signature R. Sylvest (M. D. or other) _____
Address 3903 Park Ave Date signed 8-25-45

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

00
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 Edwin D Mc Dermott

Licensed Embalmer No. 3024

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.