V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29094

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8137

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Anthonys Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0

(c) City or town St. Louis 17 VB
(If outside city or town limits, write "RURAL")

(d) Street No. 1827a Dolman St. 9
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Alois Hlinomaz (Hilman)

3. (b) If veteran, name war ------ 3. (c) Social Security No. ----

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Antonette Hlinomaz 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Unknown (Month) About (Day) 1870 (Year)

8. AGE: Years About 75 Months Unknown Days If less than one day hr. min.

9. Birthplace Czechoslovakia 6
(City, town, or county) (State or foreign country)

10. Usual occupation Tailor

11. Industry or business

FATHER
12. Name Frank Hlinomaz
13. Birthplace Czechoslovakia 6
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Antonette Hlinomaz
(b) Address 1827a Dolman St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/45 (Month) (Day) (Year)
(c) Place: burial or cremation Old SS Peter & Paul

18. (a) Signature of funeral director Wm C Mozdell
(b) Address 1926 Allen Ave.

19. (a) SEP 19 1945 (Date received local registrar) (b) J. Medich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 17th
year 1945 hour 6.50 minute P M.

21. I hereby certify that I attended the deceased from 9/14, 1945, to 9/17, 1945;
that I last saw him alive on 9/17, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral Hemorrhage

Due to Hypertension @ c̄ cardio vascular renal

Due to Syndrome

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 131 —

Of autopsy

Duration: 4 days; several years.

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) no
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Wm J Watson MD (M. D. or other)
Address 3804 Wilmington AVE Date signed 9/18/45

(Licensed Embalmer's Statement on Reverse Side)

FEB 11 1946

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 Benj. C. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen

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.