

No. 2
5-43
5-17-39
X36671

FILED DEC 3 1945
Registration District No. 160

Primary Registration District No. 3029

Registrar's No. 250

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Crystal City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
(c) City or town Crystal City
(If outside city or town limits, write "RURAL")
(d) Street No. 410 Taylor Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Pauline Kollarik
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 18
year 1945 hour 4 minute 30 P. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Joe
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased August 25, 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1943
19 41 to Nov. 18 19 45
that I last saw her alive on Nov. 18
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
57 2 23 hr. 9 min.

Immediate cause of death Cardiovascular disease
Due to _____
Due to _____

9. Birthplace _____ (City, town, or county) (State or foreign country)
10. Usual occupation House work

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
• Of operations _____
Of autopsy _____

MOTHER FATHER
11. Industry or business own home
12. Name John Bucha
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Katherine unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Joe Kollarik
(b) Address Crystal City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1945
(Month) (Day) (Year)
(c) Place: burial or cremation Crystal City

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature Z. Begen (M. D. or other)
Address Crystal City, Mo. Date signed 11-24-45

18. (a) Signature of funeral director Henry R. Politta
(b) Address Crystal City, Mo.
19. (a) 11-26-45 (Date received local registrar) (b) (Illegible) Brown (Registrar's signature)

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.....

Henry R. Politt
.....
Licensed Embalmer No. *3481*.....

P. O. Address..... *Crystal City*.....

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:

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. DecRegistration District No. 160Primary Registration District No. 2029Registrar's No. 250

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Crystal City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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

Pauline Kollank

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced

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

7. Birth date of deceased Aug 25 (Month) (Day) (Year)8. AGE: Years 57 Months 2 Days 2 (If less than one day, hr. min.)9. Birthplace Siófok, Hungary (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) (Please Brown) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1988 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

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 _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

37681