V. S. No. 2
100M—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

19265

FILED DEC 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39099

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10215

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County

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

Street No. 2615a Hickory Str. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ANNA DRMACIC

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Abt 1883 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day hr.	min.
Abt 62	—	—		✓

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Stefan Horvath
13. Birthplace Croatia (City, town, or county) (State or foreign country)

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

16. (a) Informant Frank Drmacic
(b) Address 2615a Hickory Str

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (Month) (Day) (Year)
(c) Place: burial or cremation New S.S. Peter&Paul.

18. (a) Signature of funeral director Wm C. Kemper
(b) Address 1926 Allen Av.

19. (a) DEC 10 1945 (Date received local registrar) (b) J. F. Bradecker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 8th year 1945 hour 9:20 minute P M.

21. I hereby certify that I attended the deceased from 12/2/45, 19..., to 12/8/45, 19...; that I last saw her alive on 12/8/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure

Due to Hypertension Cardio-Vascular disease

Due to —

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy none permitted

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. D. Hamilton, M.D. (M. D. or other)

Address 1515 Lafayette Ave. Date signed 12/10/45

(Licensed Embalmer's Statement on Reverse Side)

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 Ben. C. Duncan

Licensed Embalmer No. 2872

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.