S. No. 2
M—2-43
. 5-17-39
I X35697

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

2129

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 17 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

4048

State File No. 7

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 49

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Veterans Administration Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since 11/6/1945 (Specify whether
In this community 68 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

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

(d) Street No. 830 Lemay Ferry Road
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frank KALINA, Sr.

3. (b) If veteran, name war Spanish American

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Anna Kalina

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

7. Birth date of deceased February (Month) 2 (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
68	11	0	hr. min.

9. Birthplace St. Louis, (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Packer

11. Industry or business Unknown

FATHER
12. Name John Kalina
13. Birthplace (City, town, or county) Bohemia 8 (State or foreign country)

MOTHER
14. Maiden name Selma Hoffman
15. Birthplace (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Clinical Records, Vet. Admin.
(b) Address Hospital, Jefferson Barracks, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof 1/5/46 (Month) (Day) (Year)
(c) Place: burial or cremation Nat Cemetery

18. (a) Signature of funeral director Lundh Ind 6
(b) Address 7420 Michigan Av

19. (a) 1-8-46 (Date received local registrar) (b) [illegible] (Registrar's signature) MS

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2
year 1946 hour 1:20 minute A. M.

21. I hereby certify that I attended the deceased from November 6, 1945 to January 2, 1946;
that I last saw him alive on January 2, 1946;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CORONARY ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL DAMAGE, AURICULAR FIBRILLATION AND	
~~Due to~~ MYOCARDIAL INSUFFICIENCY	Unknown
Due to - - 93d	
Other conditions Cerebral Thrombosis with hemiplegia, left (Include pregnancy within 3 months of death)	Unknown

Major findings:
Of operations None
Of autopsy None

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 HARVEY E. SISK, Major, M.C. (M.D. or other)
Address Vet. Adm. Hosp., Jeff. Bks. Mo. Date signed 1/2/45

707

(Licensed Embalmer's Statement on Reverse Side)

JAN 16 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 V. E. Morris

Licensed Embalmer No. 3360

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.