DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 13 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18539

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5043

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
1321 N 19th Str
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

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

(d) Street No. 1321 N. 19th Str.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frank B. Irvine

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 23 (Day) 1899 (Year)

8. AGE: Years 46 Months 5 Days 24 If less than one day hr. min.

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

10. Usual occupation unemployed

11. Industry or business

MOTHER FATHER

12. Name Jessie Irvine

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

14. Maiden name Mattie Irven

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

16. (a) Informant Chester Cearsman

(b) Address 1321 N 19 th Str.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/46 (Month) (Day) (Year)

(c) Place: burial or cremation St Peters Cem

18. (a) Signature of funeral director Central Und. Co

(b) Address 1841 Cass ave

19. (a) JUN 5 1946 (Date received local registrar) (b) J. F. Breden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17 year 1946 hour 600 minute P M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Hypertrophic	
Due to Myocarditis	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

(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 John Gyorovski

Licensed Embalmer No. 3398

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5043

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(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)

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

3. (a) PRINT FULL NAME Frank B Ironie

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 23 (Day) 18 (Year)

8. AGE: Years 46 Months 5 Days 24 If less than one day hr. min.

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

10. Usual occupation unemployed

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

JUN 25 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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.

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(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

18540