

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18981**
Registrar's No. **1642**

FILED JUN 6 1946
Registration District No. _____

Primary Registration District No. **1003**

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

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:
2215 a Indiana Av. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2215a Indiana Av.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Frank Tomasek**
(b) If veteran, name war **NO**
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **20**
year **1946** hour **1:05** minute _____ P M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Rose** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 13 1875**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 2nd 1946 to May 18th 1946**
that I last saw him alive on **May 18th 6:30 PM 1946**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
71 2 7 hr. _____ min.

Immediate cause of death **APoplexy**
Arteria 2 - Scleros
Duration _____

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

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation **Shoe Worker**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Rose Tomasek**

(b) Address **2215a Indiana Av.**

17. (a) **BURIAL** (b) Date thereof **5/24/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Picker Cemetery**

18. (a) Signature of funeral director **Wm B Myrdell**
(b) Address **1926 Allen Av.**

19. (a) **MAY 23 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

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 **Dr. John Bruckman** (M. D. or other)
Address **1625 a So. Jefferson** Date signed _____

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..... *me*.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Benny C. Duncan*.....

Licensed Embalmer No..... *2272*.....

P. O. Address..... *1926 Allen ave*.....

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.