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**FILED** AUG 31 1946

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **6315**

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

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:  
**Barnes Hospital**  
(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 **Pennsylvania** (b) County **Somerset** **9/11**

(c) City or town **Boswell** **36**  
(If outside city or town limits, write "RURAL") **NR.**

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **2**

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Michael Paul Farkas**

3. (b) If veteran, name war **World War 2**

3. (c) Social Security No. **Unknown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **17**  
year **1946** hour \_\_\_\_\_ minute **44** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **Subarachnoid Hemorrhage** Duration

7. Birth date of deceased **June 29 1920**  
(Month) (Day) (Year)

8. AGE: Years **26** Months **0** Days **18** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **Subarachnoid Hemorrhage** Duration

Underline the cause to which death should be charged statistically.

Physician **Dr. J. H. Hoppe**

9. Birthplace **Wilbur Pennsylvania**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Mechanic**

Major findings: **Subarachnoid Hemorrhage**

Underline the cause to which death should be charged statistically.

Physician **Dr. J. H. Hoppe**

11. Industry or business **Airplane**

12. Name **Michael Farkas**

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

Additional Supplementary Information Requested

17. (a) Informant **Michael Farkas, Sr.**

14. Maiden name **Mary Kiraly**

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

17. (a) Informant **Michael Farkas, Sr.**

(b) Address **Boswell, Pennsylvania**

17. (a) **Removal** (b) Date thereof **7-17-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Boswell, Pennsylvania**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **JUL 17 1946** (Registrar's signature) **J. J. Bredeck**

AUG 30 1946

6315

**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.....

*W W Wilkinson*

Licensed Embalmer No..... 3575

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.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

3. (a) PRINT FULL NAME Michael Tarkas

3. (b) If veteran, name war II 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 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 \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Mechanic

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (c) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 July year 1946 hour \_\_\_\_\_ minute 4:30 a.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 Anterior wall Myocardial Infarction  
When the automobile he was in  
was struck by a car being driven by  
one Francis Leo Cassetta, was  
propelled into a building on  
Highway #66 about 3 miles east  
of St. Louis, Missouri, where it  
fell July 18, 1946

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
(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) Open Verdict

(b) Date of occurrence July 20, 1946

(c) Where did injury occur? 3 mi. E. of St. Louis (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury Car

23. Signature Patrick E. Taylor (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 9/14/46

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

SUPPLEMENTARY

25212