

Registration District No. **161**

Primary Registration District No. **0594**

Registrar's No. **2**

1. PLACE OF DEATH:

(a) County **MISSOURI JEFFERSON**
(b) City or town **GEDAR HILL**
(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.
In this community **5 YEARS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOHN KRIFKA**

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 **WIDOWED**

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

7. Birth date of deceased. **Nov 24 1871**
(Month) (Day) (Year)

8. AGE: Years **75** Months **2** Days **-** If less than one day hr. min.

9. Birthplace **Yugo Slavia**
(City, town, or county) (State or foreign country)

10. Usual occupation **CARETAKER**

11. Industry or business

12. Name **UNKNOWN**

13. Birthplace **YUGO-SLAVIA**
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

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

16. (a) Informant **MRS ANNA ENGELMAN**

(b) Address **GEDAR HILL Mo.**

17. (a) **BURIAL** (b) Date thereof **JAN. 27, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OLD S.S. PETER & PAUL Thomas Kulis & Son**

18. (a) Signature of funeral director **2906 GRAVOIS ST LOUIS MO**

(b) Address **Jan 24, 1947** (b) **Mrs J. H. Kuekel**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JE** **96**
(c) City or town **7301 S. BROADWAY ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JAN** day **24**
year **1947** hour **12** minute **PM**

21. I hereby certify that I attended the deceased from **Tracy 1st**
1946 to **Jan 27, 1947**
that I last saw him alive on **Jan 22, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis** Duration

Due to

Due to

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations **93E**

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?

While at work (Specify type of place) (c) Means of injury **0**

23. Signature **V.B. Edwards** (M. D. or other)

Address **GEDAR HILL** Date signed **1/24/47**

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

MOTHER FATHER

144

Date Filled 1-30-47

District File Number

District Health Officer No. 9

RECEIVED

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.....

Leo J. Budde

Licensed Embalmer No. 3989

P. O. Address St. Louis, Mo

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 726
Registrar's No. 2

Registration District No. 161 Primary Registration District No. 5594

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

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Cedar Hill
(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 years, months or days)

3. (a) PRINT FULL NAME John Krifka

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 wid

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

7. Birth date of deceased Nov. 24
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) Jan 24, 1947 (b) Mrs. J. A. Huukala
(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 _____ Day _____
Year 1947 Hour _____ minute _____ 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 _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-1589