

No. 2
2-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6587

State File No. _____
Registrar's No. **2366**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **City Infirmary**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 years** (Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME **KUBICEK, ANTONIA.**

3. (b) If veteran, name war **- none**
3. (c) Social Security No. **none**

4. Sex **Female**
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 _____

7. Birth date of deceased **April 25th 1849**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	97	10	10	hr. _____ min.

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

10. Usual occupation **Nil**

11. Industry or business _____

MOTHER FATHER

12. Name **Wm. Kubicek**
13. Birthplace **Bohemia**
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace **Ludmilla ? Bohemia**
(City, town, or county) (State or foreign country)

16. (a) Informant **City Infirmary Records**

(b) Address _____
17. (a) **Burial** (b) Date thereof **3-8-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Old Pickers Cem.**

18. (a) Signature of funeral director **H. Leidner Und. Co.**
(b) Address **2223 St. Louis Ave.,**

19. (a) **MAR 8 1947** (b) *J. Bredech*
(Date received local registrar) (Registrar's signature)

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. **5800 Arsenal St**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **5th**;
year **1947** hour **10:10 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **July 2**
the 2nd; 19 **45** to **March 5th,** 19 **47**
that I last saw **her** alive on **March 5th;** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **(1) Pulmonary edema - 8 hours (2) Old myocarditis - duration unknown.**

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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)
23. Signature *Blum Primm Bowlich* (M. D. or other) _____
Address _____ Date signed _____

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

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 P. Beckholz*
Licensed Embalmer No. *1674*
P. O. Address *2223 St. Louis 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.