

FILED APR 14 1947

1003

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

**1. PLACE OF DEATH:**  
 (a) County MISSOURI  
 (b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ENROUTE CITY HOSPITAL  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MISSOURI (b) County \_\_\_\_\_  
 (c) City or town ST. LOUIS 24 000  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3121 CALIFORNIA 9  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** ANTON A. CHONEFF  
 3. (b) If veteran, \_\_\_\_\_ name war  
 3. (c) Social Security No. 496-28-0181

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month APRIL day 3  
 year 1947 hour 11 minute 55 A.M.

4. Sex MALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife SELA 6. (c) Age of husband or wife if  
 alive \_\_\_\_\_ years  
 7. Birth date of deceased NOV. 20 1882  
(Month) (Day) (Year)

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.

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>4</u>	<u>14</u>	_____hr. _____min.

Immediate cause of death \_\_\_\_\_  
Coronary Thrombosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace GREECE 6  
(City, town, or county) (State or foreign country)  
 10. Usual occupation WATCHMAN

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

11. Industry or business \_\_\_\_\_  
 12. Name CHONEFF 6  
 13. Birthplace GREECE 6  
(City, town, or county) (State or foreign country)  
 14. Maiden name UNKNOWN  
 15. Birthplace GREECE 6  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant VASILKA CHONEFF  
 (b) Address 3121 CALIFORNIA  
 17. (a) BURIAL (b) Date thereof APRIL 9 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation ST. MATTHEW CEM.

While at work? \_\_\_\_\_  
(Specify type of place)  
 Means of injury 3  
 23. Signature Patrick E. Taylor 3  
(Name of physician) (Date)  
 Address 1300 Clark Date signed 4-11-47

18. (a) Signature of funeral director Thomas Kutis  
 (b) Address 2706 GRAVOIS  
 19. (a) APR 4 1947 (b) J. J. Brebeck  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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.....

*Leop. 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.**