

No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 15 1947  
318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 25759  
Registrar's No. 7261

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

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:  
2637a S 12th Street  
(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 Marko Kulich  
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 Married  
6. (b) Name of husband or wife Margaret (c) Age of husband or wife if alive 80 years  
7. Birth date of deceased About 1870  
(Month) (Day) (Year)

AGE:	Years	Months	Days	If less than one day
	<u>Abt</u>	<u>77</u>		hr. min.

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

10. Usual occupation Labor

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

12. Name Peter Kulich

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

14. Maiden name Mary Pastervik

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

16. (a) Informant Margaret Kulich

(b) Address 2637a S 12th Street

17. (a) Burial (b) Date thereof 8/5/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cemetery

18. (a) Signature of funeral director J. F. Prudeck  
(b) Address 1926 Allen Av

19. (a) AUG 4 1947 (b) J. F. Prudeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis  
23 (If outside city or town limits, write "RURAL")  
(d) Street No. 2637a S 12th Street  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2  
year 1947 hour 6.20 minute p M.

21. I hereby certify that I attended the deceased from 11-4-46  
\_\_\_\_\_, 19\_\_\_\_, to 8-2-47, 19\_\_\_\_  
that I last saw him alive on Aug. 1, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Squamous Carcinoma of Antrum  
Due to Complicated by pneumonia  
Other conditions 55  
(Include pregnancy within 3 months of death)

Duration  
From approx. fall of 1946

Major findings: Squamous Cell Carcinoma of Antrum  
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) (e) Means of injury \_\_\_\_\_  
23. Signature Louis J. Ryan (M. D. or other) M.D.  
Address 400 Metropolitan Bldg Date signed 8/4/47

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

MOTHER, FATHER

#1

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

Signed Benny A. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen

**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.