

S. No. 2
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5-17-39
-1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25762**
Registrar's No. **6812**

FILED JUL 26 1947

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: Missouri Baptist
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community St. Louis-Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Michael Charles Kupris
3. (b) If veteran, name war No 3. (c) Social Security No. 492-10-1592

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Eleanor B. Kupris 6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased June 9th 1914
(Month) (Day) (Year)

8. AGE: Years 33 Months 1 Days 8 If less than one day
hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Foreman

11. Industry or business Liggett-Myers Tobacco Co.

MOTHER FATHER

12. Name Michael Kupris
13. Birthplace Unknown Lithuania
(City, town, or county) (State or foreign country)
14. Maiden name Petronella Garswa
15. Birthplace Unknown Lithuania
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eleanor B. Kupris
(b) Address St. Louis, Missouri

17. (a) Burial (b) Date thereof 7/21/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Missouri

18. (a) Signature of funeral director John Kasaly
(b) Address East St. Louis Illinois

19. (a) JUL 21 1947 J. Bredenk
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4955 Schollmeyer
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17th
year 1947 hour 4:00 minute 20 PM.

21. I hereby certify that I attended the deceased from July 12
1947 to July 17 1947
that I last saw him alive on July 17 1947
and that death occurred on the date and hour stated above.

Immediate cause of death staphylococcal poliomyelitis

Due to 3/6
Due to -----

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations -----
Of autopsy Autopsy of human testes Hospital - report not completed

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 a. J. Werplein (M. D. or other) 0
Address 3507 Gloucer Date signed 7-18-47

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

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

JUL 2 - 1947

#81 62 700

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 *C. W. Cooper*

Licensed Embalmer No. *3830*

P. O. Address. *2301 Lafayette*

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.