

No. 2
1/27
17-39

FILED SEP 8 1947

Registration District No.

Primary Registration District No. 1003

Registrar's No. 3221

1. PLACE OF DEATH:

(a) County: St. Louis Mo.

(b) City or town: St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hosp.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: St. Louis

(c) City or town: St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(d) Street No.: 1812 1/2 Beardsley
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME: Joseph Kovar

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

4. Sex: Male

5. Color: White

6. (a) Single, widowed, married, divorced: 2

6. (b) Name of husband or wife.....

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

7. Birth date of deceased: 9/11/1870
(Month) (Day) (Year)

Immediate cause of death: Coronary Myocarditis

Due to.....

Due to..... J.M.A.D.

8. AGE: 76 Months Days If less than one day

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

Other conditions: (Include pregnancy within 3 months of death) 93

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause of which death should be charged statistically.

10. Usual occupation: work

11. Industry or business: work

12. Name: work

13. Birthplace: Chek Bohemia
(City, town, or county) (State or foreign country)

14. Maiden name: work

15. Birthplace: work
(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?..... (Specify type of place)

While at work?..... (e) Means of injury..... 3

23. Signature: W. J. Bredick (M. D. or other) 3
Date signed: 8/9/47

16. (a) Informant: Thos. J. Callahan

(b) Address: 1300 E. 11th St.

17. (a) Anatomical Board Date received: 8-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Mary's Hosp.

18. (a) Signature of funeral director: W. J. Bredick

(b) Address: 3503 B. St.

19. (a) AUG 29 1947 (Date received local registrar)

W. J. Bredick (Registrar's signature)

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.