

1/47
5-17-39

National Office of Vital Statistics
FILED DEC 6 1947
Registration District No. 318

Primary Registration District No.

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

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 St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

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. 1513 Franklin Ave
Memorial (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME MIKE NALBANION

3. (b) If veteran, name war.....
3. (c) Social Security No. 0

4. Sex MALE 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 alive.....
7. Birth date of deceased.....
(Month) (Day) (Year) 1896

8. AGE: Years about 71 Months - Days -
If less than one day
hr. min

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

10. Usual occupation Cook.

MOTHER FATHER

11. Industry or business.....
12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Dany Korhozen
(b) Address 1513 Franklin

17. (a) Burial Date thereof Dec - 97
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Public Funeral Home

18. (a) Signature of informant [Signature]
(b) Address 3029 Lafayette

19. (a) DEC 1 - 1947 (b) J.P. Bedeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29th
year 1947 hour 12:15 minute Noon M.

21. I hereby certify that I attended the deceased from 11/28/47
to Nov. 29th 1947
that I last saw in alive on Nov. 29th 1947
and that death occurred on the date and hour stated above.
Duration

Immediate cause of death Respiratory failure

Due to Myocardial infarction

Due to arteriosclerosis heart disease

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy.....

PHYSICIAN
Underline the cause of 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?.....
(Specify type of place)
While at work?..... (e) Means of injury.....

23. Signature [Signature] Address 1515 Lafayette Date signed 12/1/47

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

David Van Fossan

Licensed Embalmer No. *4242*

P. O. Address *3029 Lafayette St.*

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.

Registration District No. 314

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME Mike Halbanon

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years att-71 Months Days If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) J. F. [Signature]
(Date received local registrar) (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1947 Day 9
year..... 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.
immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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..... (M. D. or other).....
Address..... Date signed.....

Duration.....

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

SUPPLEMENTARY

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

40012

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