

No. 2
-5-43
5-17-39
X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6836

State File No. _____

FILED MAR 4 1948

318

Registration District No. _____

1003

Primary Registration District No. _____

1730

Registrar's No. _____

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:
St. Anthony Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oaw
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1839 S. 11th Street 9
23 (If rural, give location)
(e) Citizen of foreign country? No 0
(Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME RUDOLF OCHMAN

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 Rose Ochman 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased April 8-1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 10 9 hr. min.

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

10. Usual occupation Butcher

11. Industry or business _____

12. Name John Ochman

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

14. Maiden name Anna Shalrupa

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

16. (a) Informant Rose Ochman

(b) Address 1839 S. 11th Street

17. (a) Burial (b) Date thereof 2-21-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Middell Lind

(b) Address 1926 Allen Avenue

19. (a) FEB 10 1948 (b) J. F. Breach
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17th
year 1948 hour 4 minute 00 P. M.

21. I hereby certify that I attended the deceased from 1-19-48
to 2-17-48, 1948
and that death occurred on the date and hour stated above.
that I last saw him live on 2-17-48, 1948

Immediate cause of death _____ Duration _____

Myocardial infarction 5 hrs

Due to Coronary thrombosis 5 hrs

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

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 P. Hoffmann (M. D. or other) _____

Address 4665 So. Grand Date signed 2-18-48

WRITE PLAINLY—USE 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.....

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

Signed Benj. L. Duncan
Licensed Embalmer No. 2272

P. O. Address 1926 Allen Avenue

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.