

Registration District No. **318**Primary Registration District No. **1003**

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:
City Hospital # 1 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 hour**
 (Specify whether _____)
 In this community **40 years**
 (years, months or days)

3. (a) PRINT FULL NAME **Mary Petrovich**

3. (b) If veteran, name war **None** | 3. (c) Social Security No. **None**

4. Sex **Female** | 5. Color or race **White** | 6. (a) Single, widowed, married/
 divorced **Married**
 6. (b) Name of husband or wife **Peter Petrovich** | 6. (c) Age of husband or wife if
 alive **55** years
 7. Birth date of deceased **November 16 1997**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 **7** **1** hr. min.

9. Birthplace **Austria Hungary** 4
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**11. Industry or business **None**

MOTHER FATHER { 12. Name **Joseph Jerep**
 { 13. Birthplace **Austria Hungary** 4
 (City, town, or county) (State or foreign country)
 { 14. Maiden name **Sidonia Grassneck**
 { 15. Birthplace **Austria Hungary** 4
 (City, town, or county) (State or foreign country)

16. (a) Informant **Peter Petrovich**
 (b) Address **1517a Bremen Ave**
 17. (a) **Burial** (b) Date thereof **6/19/48**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Friedens Cemetery**
Suedmeyer & Son's

18. (a) Signature of funeral director **Suedmeyer & Son's**
 (b) Address **3934 N. 20 Street**
 19. (a) **JUN 18 1948** (b) **J. F. Bredeck**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **006**
 (c) City or town **St. Louis** 17
 (If outside city or town limits, write "RURAL")
 (d) Street No. **26 1517a Bremen Ave** 9
 (If rural, give location) 0
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **17**
 year **1948** hour **6** minute **00** A.M.

21. I hereby certify that I attended the deceased from
May 6 19**48** to **June** 19**48**
 that I last saw he alive on **July 15** 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
 Due to **Essential Hypertension**
assoc obesity

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 **Jos J. Kussler** (M. D. or dentist)
 Address **3504 N. 14th** Date signed **6-18-48**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *Neville B. Holvatter*

Licensed Embalmer No. *3696*

P. O. Address *3934 N. 20th 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.