

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063 3067

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton Ladue
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
9909 Clayton Road (rear)
 (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 Missouri (b) County St. Louis
 (c) City or town Ladue
 (If outside city or town limits, write "RURAL")
 (d) Street No. 9909 Clayton Road (Rear)
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3: (a) PRINT FULL NAME Toza Simonovich
 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, Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 10/15/1883
 (Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days 6 If less than one day hr. min.

9. Birthplace Langovet Roumania
 (City, town, or county) (State or foreign country)
 10. Usual occupation Laborer

MOTHER FATHER
 11. Industry or business _____
 12. Name Lizo Simonovich
 13. Birthplace Roumania
 (City, town, or county) (State or foreign country)
 14. Maiden name Louvia
 15. Birthplace Roumania
 (City, town, or county) (State or foreign country)

16. (a) Informant Catherine Mirjanich
 (b) Address 3155 Russell Blvd
 17. (a) Burial (b) Date thereof 6/21/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery
 18. (a) Signature of funeral director Chulick Und Co
 (b) Address 1722 S Jefferson
 19. (a) 6/21/48 (b) Carol A. [Signature]
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 21
 year 1948 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h_____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Unknown
 Due to _____
 Due to 200e
 Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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?

 _____ (Specify type of place)
 _____ (M. D. number)
 Address Commissioner of Health Date signed 6920-48

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Ladue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
9909 Clayton Rd (rear)
(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 St Louis
(c) City or town Ladue
(If outside city or town limits, write "RURAL")
(d) Street No. 9909 Clayton Rd (rear)
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME Tozer Simonovich

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

4. Sex Male 5. Color of 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 _____ years
7. Birth date of deceased Not known
(Month) (Day) (Year)

8. AGE: Years about 65 Months _____ Days _____ If less than one day
hr. _____ min. _____

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

10. Usual occupation laborer

11. Industry or business Un

MOTHER FATHER { 12. Name Lilka Simonovich
13. Birthplace Roumania Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Louvia
15. Birthplace Unknown, Roumania
(City, town, or county) (State or foreign country)

16. (a) Informant Catherine Mirjanich
(b) Address 3155 Russell Blvd
17. (a) Burial (b) Date 6/21/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cem

18. (a) Signature of funeral director Shirley F. Wood
(b) Address 1722 S. Jeff.
19. (a) 6/21/48 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
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 _____ Duration _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____
Of operations _____
Of autopsy _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

S-21635

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 Alex. A. Churchill

Licensed Embalmer No. 4143

P. O. Address 1732 S. J.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.