

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

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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED JUL 15 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21707
Registrar's No. 1258

Registration District No. 377

Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Wentzville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. VINCENT SANITARIUM. 0
(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)

3: (a) PRINT FULL NAME JOSEPH KARGACIN
3. (b) If veteran, name war No 3. (c) Social Security No. _____

4. Sex M. 0 5. Color or race W. 6. (a) Single, widowed, married, divorced M. /
6. (b) Name of husband or wife TERZA KARGACIN 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 19 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 3 3 hr. min.

9. Birthplace JUGO SLAVIA 9
(City, town, or county) (State or foreign country)
10. Usual occupation WATCHMAN

MOTHER FATHER

11. Industry or business
12. Name MATT KARGACIN
13. Birthplace JUGO SLAVIA 8
(City, town, or county) (State or foreign country)
14. Maiden name OSIA MURICH
15. Birthplace JUGO SLAVIA 8
(City, town, or county) (State or foreign country)

16. (a) Informant TERZA KARGACIN
(b) Address 2628 CAROLINE
17. (a) BURIAL (b) Date thereof JUNE 24 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation RESURRECTION
18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette Ave
19. (a) 6-24-48 (b) Office of Joseph M. D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County St. Louis
(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 2628 CAROLINE ST. 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) /
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JUNE day 21
year 1948 hour 4 minute 30 A. M.
21. I hereby certify that I attended the deceased from 6/19/1948 to 6/21/1948 1948
that I last saw him alive on 6/21/48 : 1948;
and that death occurred on the date and hour stated above.
Immediate cause of death asthma with circulatory failure Duration 4 yrs
Due to insultional psychosis 3 months
Due to 112
Other conditions insultional psychosis 3 months
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy as above
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 W. B. J. [unclear] (M. D. or other) _____
Address St. Vincent's Hosp. Date signed 6/22/48

APR 15 1948

APR 20 1953

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 Joseph Bollmer

Licensed Embalmer No. 41014

P. O. Address 3125 Lafayette Hwy

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.