

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

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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **31154**
Registrar's No. **8434**

FILED OCT 9 1948
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5027 Vernon Avenue
(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 **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5027 Vernon Avenue**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **PAULINE KAPETAN**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Milan Kapetan** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **February 15-1867**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **27th**
year **1948** hour **9** minute **15 A.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.

8. AGE: Years Months Days If less than one day
81 **7** **12** hr. _____ /min. _____

Immediate cause of death _____
Cerebral Apoplexy
Due to _____
Due to **83 a**
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace **Jugoslavia** (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**
11. Industry or business _____
12. Name **(Unknown) Markovich**
13. Birthplace **Jugoslavia** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Jugoslavia** (City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER
16. (a) Informant **Emil Kapetan**
(b) Address **5027 Vernon Avenue**
17. (a) **Burial** (b) Date thereof **9-29-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Hope Cemetary**
18. (a) Signature of funeral director **Wm. C. Myhill**
(b) Address **1926 Allen Avenue**
SEP 28 1948
19. (a) _____ (b) **J. F. Braddock**
(Date received local registrar) (Registrar's signature)

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) _____
(Means of injury) **3**
23. Signature **Tobias G. Taylor** (M.D. or other)
Address **1300 Clark** Date signed **9-28-48**

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.....

Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Benj. C. Duman

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.