FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14129

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3944

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS Mo 11
c. LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ALEXIAN BROS. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS
d. STREET ADDRESS (If rural, give location) 4425 WALLACE

3. NAME OF DECEASED (Type or Print) a. (First) MATHIAS b. (Middle) — c. (Last) SCHALJO

4. DATE OF DEATH (Month) (Day) (Year) APRIL 30, 1949

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH OCT. 6 1886

9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR Months 6 Days 24 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Loader

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) HUNGARY 4

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph SCHALJO

13b. MOTHER'S MAIDEN NAME MARY KILLIAN

14. NAME OF ~~HUSBAND~~ OR WIFE ANNA SCHALJO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 492-01-3296

17. INFORMANT'S SIGNATURE OR NAME ANNA SCHALJO ADDRESS 4425 WALLACE

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) [illegible] stones in hepatic duct
DUE TO (c) Terminal Bronchopneumonia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION [illegible]

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 124

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 5810

22. *I hereby certify that I attended the deceased from* April 15, 1949, *to* April 30, 1949, *that I last saw the deceased alive on* April 30, 1949, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE [illegible] Marzus (Degree or title)

23b. ADDRESS 3606 Gravois

23c. DATE SIGNED 8-2-49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE MAY 3, 1949

24c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS

24d. LOCATION (City, town, or county) ST. LOUIS Mo. (State)

DATE REC'D BY LOCAL REG. MAY 2 1949

REGISTRAR'S SIGNATURE J B [illegible]

25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis ADDRESS 2906 Gravois

(Licensed Embalmer's Statement on Reverse Side)

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

La 7380
1 x 5 Pm

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 _____ Student Embalmer No. _____ working under my personal supervision.

Signed Homer C. Dell

Signed _____
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 Grava

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.