

FILED OCT 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

34860

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6073 Registrar's No. 367

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Rural Perry Twp.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Rural Perry Twp.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rd Bonne Terre 1</u>		d. STREET ADDRESS (If rural, give location) <u>Rd Bonne Terre</u>	

3. NAME OF DECEASED (Type or Print) <u>MICHAEL</u>	a. (First)	b. (Middle)	c. (Last) <u>MAGURA</u>	4. DATE OF DEATH <u>Oct 9 1949</u>
-------------------------------------------------------	------------	-------------	-------------------------	---------------------------------------

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 11, 1867</u>	9. AGE (In years last birthday) <u>81</u>	if UNDER 1 YEAR Months <u>11</u> Days <u>28</u>	if UNDER 24 HRS. Hours <u></u> Min. <u></u>
--------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	----------------------------------------------------	------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME <u>Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Johnson</u>	14. NAME OF HUSBAND OR WIFE <u>Agnes Magura</u>
--------------------------------------	---------------------------------------------	----------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Michael Magura Jr</u>	ADDRESS <u>Rd Bonne Terre</u>
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	---------------------------------------------------------------	----------------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>  <u>18 mths</u>  <u>1991</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cancer of foot</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	-------------------------------------------------------------------------------------

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)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from sep-20-1948 to oct-9-1949, that I last saw the deceased alive on oct-7-1949, and that death occurred at 11:08 m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. L. Evans M.D.</u>	(Degree or title)	23b. ADDRESS <u>Bonneterre Mo.</u>	23c. DATE SIGNED <u>10-10-49</u>
-------------------------------------------	-------------------	---------------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 12, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Bonne Terre Mo.</u>
------------------------------------------------------------	----------------------------------	--------------------------------------------------------------------	-------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>Oct. 12, 1949</u>	REGISTRAR'S SIGNATURE <u>Ether Rudolph</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin H. Co. Bonne Terre Mo</u>	ADDRESS
--------------------------------------------------	-----------------------------------------------	---------------------------------------------------------------------------	---------

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

RECEIVED 10-18-49

Health Officer No. 4

Product File Number 1049-1370

Date Filed

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 Clarence J. Claywell

Signed Student Embalmer

Licensed Embalmer No. 3706

P. O. Address

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.