

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38930

State File No. _____

#117028

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10110

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2179	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 2620 Virginia Ave. 0			
3. NAME OF DECEASED (Type or Print)		a. (First) JULIA		b. (Middle) PREGALDIN	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Nov. 27th, 1950			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH Oct. 6, 1875	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri 0	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Peter Pregaldin		13b. MOTHER'S MAIDEN NAME Zeline Chochard	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT'S SIGNATURE OR NAME Lorraine Brown--		ADDRESS 3015 Shenandoah			
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) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		MEDICAL CERTIFICATION Thrombosis Rt. Subclavian- striate artery.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 332X	
22. I hereby certify that I attended the deceased from <u>11/25/50</u> , 19 <u>50</u> , to <u>11/27/50</u> , 19 <u>50</u> ; that I last saw the deceased alive on <u>11/27/50</u> , 19 <u>50</u> , and that death occurred at <u>10:00 AM</u> from the causes and on the date stated above.					
23a. SIGNATURE John T. Swinton, M.D.		(Degree or title)		23b. ADDRESS 1515 Lafayette Ave.	
23c. DATE SIGNED 11/27/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/1/50	
24c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri			
DATE REC'D BY LOCAL REG. 12 28 1950		REGISTRAR'S SIGNATURE J. B. Swinton		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldrich	
		ADDRESS 3634 Gravois Ave.			

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Robert Wheeler

Signed.....
Student Embalmer

Licensed Embalmer No. 2128

P. O. Address. St Louis mo

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.