

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9090
 Do not use this space.

REC'D APR 12 1939

791
 1008

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No.....

(c) City St. Louis..... (d) Street No. City Hospital No. 1..... St. 21
 (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

D18606

2. PRINT FULL NAME Frank Vausha
3519 Evans

(a) Residence, No. (Usual place of abode, if no street address, write county or city) St. 21 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Vausha

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 10 1857

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>81</u>	<u>5</u>	<u>8 14</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as saw mill, bank, etc. Carpenter

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER

13. NAME Peter Vausha

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) France

MOTHER

15. MAIDEN NAME Josephine Simon

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) France

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE 3/27/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mullen Brothers
4259 Lindell

20. FILED MAR 27 1939 J. D. Budick
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/24/39, 19.....

22. I HEREBY CERTIFY, That I attended deceased from 3/22/39, 19..... to 3/28/39, 19.....
 I last saw him alive on 3/24/39, 19..... Death is said to have occurred on the date stated above, at 5.30 p.
 The principal cause of death and related causes of importance were as follows:
Myocardial Insufficiency

Date of onset

Other contributory causes of importance: 93

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) A. Potaschick M.D. M. D.
 (Address) City Hospital No. 1

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Licensed Embalmer No.....

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, above space should be left blank.