

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STANDARD CERTIFICATE OF DEATH

33904

State File No.

8442

Registration District No. 1003

Primary Registration District No.

Registrar's No.

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 Stepus Greduchus Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: 1 day in hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo County St. Louis [24]

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. Shank 47 - Fort of Venable
(If rural, give location)

(e) If foreign born, how long in U. S. A. 18 years

3. (a) PRINT NAME Stepus Greduchus

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex Male

5. (a) or (b) race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18
year 1939 hour 9 minute 05 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 73 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Lithuania
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Unknown

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

Immediate cause of death Plumie Myocarditis

Due to Arteriosclerosis

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

MOTHER FATHER

16. (a) Informant's own signature John Schiele

(b) Address 5306 Newport

17. (a) Removal (b) Date thereof 3/19/39
(Month) (Day) (Year)

(c) Place: burial or cremation Hicksville, Missouri

18. (a) Signature of funeral director Wm. J. Bueck

(b) Address _____

19. (a) OCT 3 1939 (Date received local registration)

(b) 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? _____

23. Signature Joseph M. Quinn (Specify type of place) _____
Address Deputy Coroner (e) Means of injury _____

24. Signature _____ (Mr. D. or other)

Address _____ Date signed _____

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 Raymond E Garke

*city license
180*

Licensed Embalmer No. 3985

P. O. Address. ST Louis, Mo

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, above space should be left blank.