No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34132

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 8829

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

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST. JOHNS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 DYS. (Specify whether years, months or days)

In this community 55 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis

(c) City or town St Louis 26
(If outside city or town limits, write "RURAL")

(d) Street No. 1532 A. N. 17TH STR. 0
(If rural, give location)

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

3. (a) PRINT FULL NAME LEON TOLKACZ.

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MARY TOLKACZ

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased MARCH (Month) 30 (Day) 1875 (Year)

8. AGE: Years 65 Months 6 Days 25 If less than one day — hr. — min.

9. Birthplace ILLINOIS (City, town, or county) 1 (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business TEAMSTER

FATHER
12. Name LEON TOLKACZ
13. Birthplace GERMANY (City, town, or country) (State or foreign country)

MOTHER
14. Maiden name DONT KNOW
15. Birthplace " " " (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Kate Maguire
(b) Address 3648 Garfield ave.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 28-1940 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Brockland and Co
(b) Address 1827 HOGAN STR

19. (a) OCT 26 1940 (Date received local registrar) (b) J. T. Burdesch (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25 year 1940 hour 6 35 minute P. M.

21. I hereby certify that I attended the deceased from Sep 15-1940, 1940 to October 25, 1940 that I last saw he alive on October 25, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chr myocarditis	
acute myocardial failure	10/25/40
Pneumonia-Terminal,	10/25/40
Due to unspecified	10/25/40
cerebrovascular	10/25/40
Apoplexy	10/25/40
Due to Chr interstitial	10/15/40
nephritis	

Other conditions (Include pregnancy within 3 months of death) 0

Major findings: Of operations none 0

Of autopsy none

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. H. Trunger M.D. (M. D. or other)
Address 495 Maryland Date signed 10/25/40

(Licensed Embalmer's Statement on Reverse Side)

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. Albert N. Hoppe

Licensed Embalmer No. 1861

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.