

No. 2
13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **4927**
Registrar's No. **1175**

REC'D MAR 25 1941 791

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **DePaul Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days**. (Specify whether)
In this community **30 Years**.
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**. (If outside city or town limits, write "RURAL") **17**
(d) Street No. **1703 A Geyer Ave.** (If rural, give location) **23**
(e) If foreign born, how long in U. S. A.? **30** years.

3. (a) PRINT FULL NAME **THOMAS DRZIK**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **3**
year **1941** hour **7 15 P.M.** M.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widower**
6. (b) Name of husband or wife **Anna Drzik** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb 28 1879**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **January 31**, 1941 to **February 3**, 1941.
that I last saw him alive on **February 3**, 1941, and that death occurred on the date and hour stated above.
Immediate cause of death **Cerebral Hemorrhage** **3** days

8. AGE: Years **61** Months **11** Days **3** If less than one day _____ hr. _____ min.

Due to **Arterio Sclerosis**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

9. Birthplace **Bohemia** (City, town, or county) (State or foreign country) **8**
10. Usual occupation **Retired Iron Moulder**
11. Industry or business _____
12. Name **Thomas Drzik**
13. Birthplace **Bohemia** (City, town, or county) (State or foreign country) **8**
14. Maiden name **Eva Nagy**
15. Birthplace **Bohemia** (City, town, or county) (State or foreign country) **8**

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

MOTHER FATHER {
16. (a) Informant **Elizabeth Jakovac**
(b) Address **1703 A Geyer Ave.**
17. (a) **Burial** (b) Date thereof **Feb 6/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Concordia Cem.**
18. (a) Signature of funeral director **Shoodutis & Son**
(b) Address **2906 Gravois Ave.**
19. (a) **FEB 4 1941** (Registrar's signature) **Shoodutis & Son**

22. If death was due to external causes, fill in the following: **0**
(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?
While at work? _____ (Specify type of place) (e) Month of injury **0**
23. Signature **A. R. Ginterhoff** (M. D. or other) **2/4/41**
Address **1739 N Grand** Date signed _____

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

6-1-1915

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.....

Thos Lutes

Registered Apprentice No.....

working under my personal supervision.

Signed.....
Thos Lutes

Licensed Embalmer No. *1619*

P. O. Address *2906 Favon*

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.