

Registration District No. 791

Primary Registration District No. 1003

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  
4039 Clayton Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4039 Clayton Ave  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9<sup>th</sup>  
year 1942 hour 1:30 minute P. M.  
21. I hereby certify that I attended the deceased from Oct.  
1942 to April 9 1942;  
that I last saw him alive on April 9 1942;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Tongue. Duration 1 mos.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions None.  
(Include pregnancy within 3 months of death)

Major findings: C. of Tongue, metastasis of neck.  
Of operations \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Dr. P. H. Koch (M. D. or other) \_\_\_\_\_  
Address 3110 P. Board Date signed 4/10/42

3. (a) PRINT FULL NAME Frank Seper  
3. (b) If veteran, name war No  
3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Rose Seper  
6. (c) Age of husband or wife if alive 56 years  
7. Birth date of deceased Feb 3 1887  
(Month) (Day) (Year)

8. AGE: Years 55 Months 2 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation watchman

11. Industry or business \_\_\_\_\_

12. Name Steve Seper

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

14. Maiden name Rose Sali

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

16. (a) Informant Mrs. Rose Seper

(b) Address 4039 Clayton Ave

17. (a) Burial (b) Date thereof 4-11-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter's Paul

18. (a) Signature of funeral director Kriegshammer-Spartaco

(b) Address 4228 St. Hugo St. St. Louis, Mo.

19. (a) APP 10 1942 (b) \_\_\_\_\_  
(Date received by registrar) (Registrar's signature)

Stue (Licensed Embalmer's Statement on Reverse Side)

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

72

Mr. Book  
3-15-40 Grand 3-5

**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 *Edwin M. Herriott*  
Licensed Embalmer No. *3024*

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, fact should be so stated above.**