

H844

V. S. No. 2
DM-9-4-41
Rev. 5-17-39
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12486

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12486

FILED MAY 7 1942

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3805

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 Days
(Specify whether years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....

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

(d) Street No. 719 Carroll St.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Anna Chabdaratz

3. (b) If veteran, name war.....

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

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

7. Birth date of deceased: August 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>8</u>	<u>2</u> hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER

12. Name Uzur

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

14. Maiden name.....

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

16. (a) Informant Bessie Novakovich

(b) Address 3513 So. Broadway

17. (a) Burial (b) Date thereof 4/28/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Charles Lind. Co

(b) Address 1722 So. Jefferson Ave.

19. (a) APR 29 1942 (b) J. F. Bradeck
(Date received local health officer's report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26,
year 1942 hour 8:55 minute A. M.

21. I hereby certify that I attended the deceased from April 20, 19 42 to April 26, 19 42.
that I last saw her alive on April 26, 19 42.
and that death occurred on the date and hour stated above.

Immediate cause of death:
Atherosclerosis
Chronic myocarditis

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death)
93h
93c

Major findings:
Of operations.....

Of autopsy.....

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 0

23. Signature M. M. Karl (M. D. or other)
Address 1515 Lafayette Avenue Date signed 4/27/42

(Licensed Embalmer's Statement on Reverse Side)

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

3805

3805

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.....

B. N. Finer

Licensed Embalmer No. 1591

P. O. Address 4106a Botanical

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.