

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6116**

1. PLACE OF DEATH:

(a) County Louis

(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 6 Days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_

(c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 2821 N. BUDY  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Charles Fugarski

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

3. (c) Social Security No. \_\_\_\_\_

4. Sex M. 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife DORINDA 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DEC 19 1889  
(Month) (Day) (Year)

8. AGE: Years 53 Months 6 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace UNK \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name ANDREW

13. Birthplace UNK \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name MARY

15. Birthplace UNK \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS ASHTON

(b) Address 4646 ST FERDINAND

17. (a) BURIAL (b) Date thereof 7-7-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director SULLIVAN BROS

(b) Address 2849 N. EUCLID

19. (a) JUL 6 1943 (b) J. F. Brudek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4, year 1943 hour 8:20 minute P. M.

21. I hereby certify that I attended the deceased from June 29, 1943 to July 4, 1943; that I last saw him alive on July 4, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Brain Tumor; Benign?

Due to 56

Due to \_\_\_\_\_

Other conditions Brain Tumor  
(Include pregnancy within 3 months of death)

Major findings: Brain Tumor

Of operations \_\_\_\_\_

Of autopsy Brain Tumor

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)

23. Signature L. S. [Signature] (M. D. or other) \_\_\_\_\_

Address City Hospital Date signed 7-6-43

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

---

---

**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 Mayfield*

Licensed Embalmer No.....

*3077*

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.**