

FILED SEP 8 1944 318

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 7399 ✓

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:  
Lutheran Hospital  
(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 Missouri (b) County 000  
17  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3539 Iowa Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 1

3. (a) PRINT FULL NAME Paul Mnich

3. (b) If veteran, name war ---- 3. (c) Social Security No. 488-09-9731

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Tekla Mnich 6. (c) Age of husband or wife if alive 47 years  
 7. Birth date of deceased June 21 1896  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>2</u>	<u>2</u>	hr. min.

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

10. Usual occupation Foundry Worker

11. Industry or business .....

12. Name John Mnich

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

14. Maiden name Agatha

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

16. (a) Informant Tekla Mnich

(b) Address 3539 Iowa Ave.

17. (a) Burial (b) Date thereof 8/26/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New SS Peter & Paul

18. (a) Signature of funeral director Wm. C. Moyell

(b) Address 1926 Allen Ave

19. (a) AUG 26 1944 (b) J. F. Bredel  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23rd  
 year 1944 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from July 19 44 to Aug 23rd 19 44  
 that I last saw him alive on Aug 23 19 44  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Coronal Disease 2 more

Due to Secondary aneurysm

Due to Coronary thrombosis 2 yrs

Other conditions 124  
(Include pregnancy within 3 months of death)

Major findings: Of operations .....

Of autopsy .....

Duration

2 more

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 A. M. Grant (M. D. or other) MD

Address 3651 Grand St Date signed 9/1

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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen

**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.**