

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5418 Partridge
(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

3. (a) PRINT FULL NAME **CLARA PERHAT**

3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married,** **divorced** **Widowed**

6. (b) Name of husband or wife **Toman Perhat** **6. (c) Age of husband or wife if** **alive** _____ **years**

7. Birth date of deceased **Unknown** **About** **1869**
(Month) (Day) (Year)

8. AGE: Years **About 76** Months **Unknown** Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ **Croatia**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Nikola Antich**

13. Birthplace _____ **Croatia**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace _____ **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Louis Perhat**

(b) Address **5418 Partridge**

17. (a) Burial _____ **(b) Date thereof** **3/27/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Wm. C. Maydell**

(b) Address **1926 Allen Ave.**

19. (a) Date of local registrar **MAP 2** **(b) J. F. Bredeek**
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **1**
(If outside city or town limits, write "RURAL")
(d) Street No. **5418 Partridge**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **27**
year **1945** hour **10** minute **30** A. M.

21. I hereby certify that I attended the deceased from **3/21/45** **19.45** to **3/24/45** **19.45**
that I last saw him **alive** on **3/23/45** **19.45**
and that death occurred on the date and hour stated above.

Immediate cause of death **(Uremia) - acute nephritis**
Due to **Ca of bladder, urinary**
Due to **Ca of cervix**
Other conditions **Primary in cervix**
(Include pregnancy within 3 months of death)

Duration

3/21/45

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
H/S

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 **Wm. C. Maydell** (M. D. or other) _____
Address **1926 Allen Ave.** Date signed **3/27/45**

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 *H. M. Davis*

Licensed Embalmer No. *3741*

P. O. Address *1926 Allen Ave*

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.