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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17256
Registrar's No. 16-61

Registration District No. 161

Primary Registration District No. 5594

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

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Meramec Falls, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Joseph Hill Infirmary 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-day (Specify whether)

In this community 40 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96

(c) City or town Kirkwood 4
(If outside city or town limits, write "RURAL")

(d) Street No. St. Arnes Home 3
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John S. Purdokas

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 W.

6. (b) Name of husband or wife Margaret

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

7. Birth date of deceased June 24th., 1866
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29th., year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Apr 1, 1945 to May 22 1945 that I last saw h. _____ alive on _____, 1945; and that death occurred on the date and hour stated above.

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|-----------|----------|----------------------|
| <u>78</u> | <u>11</u> | <u>5</u> | hr. _____ min. _____ |

Immediate cause of death Arteriosclerotic Fibrillation 3 wh.

Due to _____

Due to _____

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

10. Usual occupation Retired Sexton

Other conditions Generalized Arteriosclerosis (Include pregnancy within 3 months of death)

11. Industry or business St. John's Church Stanislano

12. Name _____

13. Birthplace Unknown (State or foreign country)

14. Maiden name Unknown (State or foreign country)

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

Major findings: Of operations 950

Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Adele Kowalewski

(b) Address 756 Hamilton Ave.

17. (a) Burial (b) Date thereof 6-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) 29 May 1945 (b) J. T. Aronsrud
(Date received local registrar) (Registrar's signature)

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 J. J. Ullman (M. D. or other) MD

Address 53 W. Big Bend Date signed June 1945

386

(Licensed Embalmer's Statement on Reverse Side)

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

Stanley Marshall

Licensed Embalmer No.

2868

P. O. Address

3840 Lindell

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 161Primary Registration District No. 0594

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Jefferson
 (b) City or town Meramec
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph Hill Infirmary
 (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 NAMEJohn S. Purdum3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex m 5. Color or
race w 6. (a) Single, widowed, married,
divorced m6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased June 24
(Month) (Day) (Year)8. AGE: Years _____ Months _____ Days _____ If less than one day
_____ hr. _____ min.9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. A. Towns
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 9
Year 1995 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline
the cause to
which death
should be
charged sta-
tistically.

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?

 (Specify type of place) (e) Means of injury _____

While at work? _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

17256