

FILED SEP 14 1945
318

1003

Registration District No.

Primary Registration District No.

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 2 Weeks
(Specify whether
In this community 39 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3425 Magnolia Ave.
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Novosak

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

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sofia 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Nov. 24, 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 9 13 hr. 7 min.

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

10. Usual occupation Auto Car Washer

11. Industry of business _____

MOTHER FATHER { 12. Name Martin Novosak
13. Birthplace Czechoslovakia (City, town, or county) (State or foreign country)
14. Maiden name Maryn Sulack
15. Birthplace Czechoslovakia (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sofia Novosak
(b) Address 3425 Magnolia Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-45 (Month) (Day) (Year)
(c) Place: burial or cremation New Pickers Cemetery

18. (a) Signature of funeral director Arthur J. Dornelle
(b) Address 3850 Lindell

19. (a) SEP 10 1945 (Date received local registrar) (b) J. McClellan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7 year 1945 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 7, 1945 to Sept 7, 1945 that I last saw him alive on Sept 7 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary disease

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 114

Major findings: Of operations 114

Of autopsy _____

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 R. Berg (M. D. or other) R. Berg
Address 253 N. 3rd St. Date signed 9/10/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

728288
J. J. Jones

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 W. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.

Registration District No. 319 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Frank Novosak
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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased m 24 1945
(Month) (Day) (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Chesterbrook
(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) Oct 30 1945 (b) J. F. Bredich
(Date received local registrar) (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 Oct year 1945 hour 10 minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I saw him _____ 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 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 _____ (M. D. or other) _____

Address _____ Date signed _____

