

No. 2  
-5-43  
-17-39  
X38671

**FILED** JAN 11 1946  
318

1003

Registrar's No. **11339**

Registration District No. **318** Primary Registration District No. **1003**

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:  
**St Johns Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7 days**  
(Specify whether years, months or days) **7 days**

3. (a) PRINT FULL NAME **ROOLPH ZOBRIK**

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

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **Aug 21 1881**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**64 4 4** hr. min.

9. Birthplace **Clinton County Ill**  
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

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

12. Name **John Zobrik**

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

14. Maiden name **Mary Datt. Kofler**

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

16. (a) Informant **Boulangier Funeral Home**

(b) Address **Highland 2 ee**

17. (a) **Removal** (b) Date thereof: **12-26-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Ill**

18. (a) Signature of funeral director **Boulangier Funeral Home**

(b) Address **Highland 2 ee**

19. (a) **DEC 27 1945** (b) **J. Z. Bredeek**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **999**  
(c) City or town **Highland** (If outside city or town limits, write "RURAL") **11**  
(d) Street No. **1** (If rural, give location) **NR**  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **25** year **1945** hour **5:40** minute **AM**

21. I hereby certify that I attended the deceased from **Dec 13 1945** to **Dec 25 1945** that I last saw him alive on **Dec 25 1945** and that death occurred on the date and hour stated above.

Immediate cause of death **General abdominal Carcinomatosis**

Due to **Unable to determine the origin**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: **As above**

Of operations \_\_\_\_\_  
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 **W. J. Gallagher** (M. D. or other) **MD**  
Address **674 N. Grand** Date signed **12-25-45**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 John Ketter

Licensed Embalmer No. 3880

P. O. Address St. Louis, Mo.

**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.**