

S. No. 2
OM-5-43
v. 5-17-39
I X36671

FILED SEP 13 1946

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri.**

(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. Louis City Hospital-Max C. Starkloff**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days**
(Specify whether _____)

In this community **40 years**
years, months or days)

3. (a) PRINT FULL NAME **PETER BARICH**

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

4. Sex **M** **5. Color or** **W** **6. (a) Single, widowed, married,**
race _____ divorced _____

6. (b) Name of husband or wife **Antonette** **6. (c) Age of husband or wife if**
alive **60** years

7. Birth date of deceased **June 6, 1883**
(Month) (Day) (Year)

8. AGE: Years **63** Months **2** Days **27** If less than one day
hr. min.

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

10. Usual occupation **bar-tender**

11. Industry or business **retired**

MOTHER FATHER

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 **Milan Barich**
(b) Address **2742 Caroline Street**

17. (a) cremation **(b) Date thereof** **9-3-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Missouri Crematory**

18. (a) Signature of funeral director **A. W. McLaughlin**
(b) Address **2301 Lafayette Avenue**

19. (a) SEP 3 1946 **(b) J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **2224a Rutger Street**
Memorial (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **3rd**
year **1946** hour **2:50** minute **A** M.

21. I hereby certify that I attended the deceased from **9/2/46**
_____, 19____, to **Sept. 3rd** 19 **46**
that I last saw h. **im** alive on **Sept. 3rd** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Lobar Pneumonia with Empyema (Right) **1 mo**

Due to _____

Due to _____

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

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy **Lobar Pneumonia with empyema Rt**

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)

Signature **George P. Smith** **9/3/46**
1515 Lafayette (City or town) (State) (Date)

Address _____ Date signed _____

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

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.

NOT EMBALMED

Signed

L R Cooper

Licensed Embalmer No. *3633*

P. O. Address *2301 Lafayette 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.