

FILED JAN 13 1947

11016

Registration District No.

318

Primary Registration District No.

1003

Registrar's 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:  
3500 S. BROADWAY  
 (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 Joseph BRATOVICH  
 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 MARCH 15 1891  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 9 6 hr. min.

9. Birthplace.....  
 (City, town, or county) (State or foreign country) Jugoslavina  
 10. Usual occupation LABORER

11. Industry or business.....  
 12. Name UNKNOWN BRATOVICH  
 13. Birthplace JUGOSLAVIA  
 (City, town, or county) (State or foreign country)  
 14. Maiden name UNK  
 15. Birthplace JUGOSLAVIA  
 (City, town, or county) (State or foreign country)

16. (a) Informant Joe Bracic  
 (b) Address 3500 S. Broadway  
 17. (a) Burial (b) Date thereof DEC 24 1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation New S.S. Peter & Pauls  
 18. (a) Signature of funeral director E. J. Schnur  
 (b) Address 3125 Lafayette St  
 19. (a) DEC 23 1946 (b) J. F. Bradeau  
 (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. 3500 S. BROADWAY  
 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27  
 year 1946 hour 12 minute 17 P.M.

21. I hereby certify that I attended the deceased from....., 19....., 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 Compound fracture of base of skull  
fracture of brain when struck  
by an automobile from unknown  
who did not stop around  
1201 E. W. St. 22, 1946 on front of  
3500 S. Broadway  
Admitted as Worker of Party  
or Parties in unknown  
 Other conditions (Include pregnancy within 3 months of death) None

Major findings: 170  
 Of operations.....  
 Of autopsy..... 21

## 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) Homicide  
 (b) Date of occurrence Dec 22 1946  
 (c) Where did injury occur? St. Louis Mo  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Street

While at work?..... (Specify type of place)  
 (e) Means of injury Automobile  
 23. Signature Alfred J. Kelly (M. D. or other) 3  
 Address 1323 1/2 St Date signed 12/23/46

**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.....

*Joe B. Wallmer*

Licensed Embalmer No. *4014*

P. O. Address.....

*St. James 45th*

**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. *318*

Primary Registration District No. *1003*

Registrar's No. *11016*

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:  
(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

*Joseph Bratovich*

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 *5*

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

7. Birth date of deceased *mar 15*  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
*65 9 15* 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. F. Bratovich*  
(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..... Day..... Year.....  
*Dec 2 1946* 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)

PHYSICIAN

Major findings:  
 Of operations.....

Of autopsy.....

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.....

SUPPLEMENTARY

MOTHER FATHER

42177

866-200