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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 24 1947
#68094

318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6249
Registrar's No. 1531

Registration District No. _____ Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town ST. LOUIS, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. LOUIS CITY HOSPITAL *O*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 912a S. Vandeventer Ave.,
(If rural, give location)

(e) Citizen of foreign country? ? (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ANTAL FARKAS

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

4. Sex male *O* 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 Unk.
(Month) (Day) (Year)

8. AGE	Years	Months	Days	If less than one day
<u>abt-79?</u>				hr. min.

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

10. Usual occupation _____

11. Industry or business Unknown

MOTHER FATHER {

12. Name Unknown

13. Birthplace Unknown
(City, town, or County) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant J. Wislizenus

(b) Address 6954 Plateau

17. (a) Burial (b) Date thereof 2/15/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mayer Vnd., Co.

(b) Address 4356 Lindell Blyd.

19. (a) FEB 14 1947 (b) F. Bredet
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 13,
year 1947 hour 11:15 minute A. M.

21. I hereby certify that I attended the deceased from 2-10-47
to 2-13-47

that I last saw him alive on 2-13-47
and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition
Garcinoma of oesophagus

Due to _____

Due to _____

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

Duration ?

Major findings:
Of operations _____

Of autopsy L. of Oesophagus

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? _____

23. Signature George J. Parker, M.D.
(Specify type of place) (a. D. or other)

Address 1515 LAFAYETTE

While at work? _____ (c) Means of injury _____

Date signed 2-13-47

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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.....
.....
Licensed Embalmer No.....
P. O. Address.....

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.