

No. 2
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5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15515**
Registrar's No. **4680**

FILED MAY 14 1947

Registration District No. **318**

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**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthony Hospital *O*
(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)

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. **223 Victor Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No) *O*
If yes, name country.....

3. (a) PRINT HARRIET ANN PARASHAK
FULL NAME

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

4. Sex **Female** / 5. Color **White** race 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 **April 3-1947**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 6 hr. min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business.....

12. Name **Gregory Parashak**

13. Birthplace **St. Francois, Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Regina Saulgala**

15. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Gregory Parashak**

(b) Address **223 Victor Street**

17. (a) **Burial** (b) Date thereof **May 9-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olive**

18. (a) Signature of funeral director *Model*
(b) Address **1926 Allen Avenue.**

19. (a) **MAY 9 1947** (b) *J. F. Bredeek*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **9th**
year **1947** hour **3** minute **00** P. M.

21. I hereby certify that I attended the deceased from **April 3**, 1947, to **May 9**, 1947.

that I last saw him alive on **May 9**, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal obstruction** Duration

Due to **congenital atresia of descending + sigmoid colon**

Due to.....
Other conditions..... (Include pregnancy within 3 months of death) **157**

Major findings: Of operations **atresia of descending & sigmoid colon**
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) **no**

(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 *O*

23. Signature *W. H. ...* (M. D. or other)

Address **520 N. Wilmington Ave** Date signed **5-8-47**

Made

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.....

Not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Ben J. Duncan*

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Avenue

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.