

S. No. 2  
-12-45  
5-17-39  
P I X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED SEP 18 1947  
318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32931

State File No. ....

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 8494

1. PLACE OF DEATH:

(a) County Cl. Lewis, Mo  
(b) City or town Cl. Lewis, Mo  
(c) Name of hospital or institution: James Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 months  
In this community 13 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 96  
(c) City or town University City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7030 Dartmouth 5  
N.R. (If rural, give location)  
(e) Citizen of foreign country? (No)  
If yes, name country

3. (a) PRINT FULL NAME Hitzky Regina

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

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

6. (b) Name of husband or Late 6. (c) Age of husband or wife if alive 47 years  
7. Birth date of deceased Oct 10 - 1894  
(Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 28 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business Housewife

12. Name Hitzkych Vogel

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

14. Maiden name Sarah Steiner

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

16. (a) Informant Elva Patasnik

(b) Address 7030 Dartmouth

17. (a) Burial (b) Date thereof 9-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Youngstown Ohio

18. (a) Signature of funeral director Henkander

(b) Address 5010 Enright

19. (a) SEP 8 1947 (b) F. R. Broady  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 8  
year 47 hour 5 minute 59 A.M.  
21. I hereby certify that I attended the deceased from 5-1  
1947, to 9-8 1947  
that I last saw h. live on 9-8 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Renal Failure Duration

Due to Acute pyelonephritis

Due to Other: Broncho-pneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 10/20

Of autopsy none performed

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature F. R. Broady (M. D. or other)

Address James Hospital Date signed 9-8-47

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

MOTHER FATHER

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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

*J. B. Chamberlain*

Licensed Embalmer No. *3669*

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.**