No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 20 1947
Registration District No. 3747

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 36719
Registrar's No. 2132

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 436 days (Specify whether In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 4147 Taft (If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME TURK, MATT
3. (b) If veteran, name war
3. (c) Social Security No. 497-05-6026
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 September (Month) 25 (Day) 1909 (Year)

8. AGE: Years 38 Months 0 Days 14 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Tailor
11. Industry or business
FATHER
12. Name Jacob Turk
13. Birthplace (City, town, or county) Hungary (State or foreign country) 4
MOTHER
14. Maiden name Anna Wingert
15. Birthplace (City, town, or county) Hungary (State or foreign country) 4
16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/47 (Month) (Day) (Year)
(c) Place: burial or cremation Resurrection Cemetery
18. (a) Signature of funeral director Wacker-Helderle U. & L. Co.
(b) Address 3634 Gravois, St. Louis, Mo.
19. (a) 10-14-47 (Date received local registrar) (b) Cecil A. J. Shaw (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9 year 1947 hour 3 minute 07 P.M.
21. I hereby certify that I attended the deceased from 7-30, 1946, to 10-9-, 1947; that I last saw him alive on 10-9-, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	17 yrs. (??)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 ev

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature [signature] (M. D. ~~or other~~)
Address Robert Koch Hospital Date signed 10-9-47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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 Frank J. Hyland

Licensed Embalmer No. 2645

P. O. Address W Saint Mo

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.