

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43507**

FILED JAN 9 1948 **318**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11220**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Barnes Hospital**
(If not in hospital or institution, write street number or name of street)

(d) Length of stay: In hospital or institution **5 days**
(Specify whether years, months or days)

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. **4582 Pope Ave.**
(If rural, give location)

(e) Citizen of foreign country? **yes** (Yes or No)
If yes, name country **Yugoslavia**

3. (a) PRINT FULL NAME **Teresa Sobol**

3. (b) If veteran, name war **none**

3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **white**

6. (b) Name of husband or wife **John Sobol**

6. (c) Age of husband or wife if alive **51** years

7. Birth date of deceased **Nov. 15 1883**
(Month) (Day) (Year)

8. AGE: Years **64** Months **1** Days **8**
If less than one day hr. min.

9. Birthplace **Drivenik Yugoslavia**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business **own home**

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 **John Sobol**

(b) Address **4582 Pope**

17. (a) **burial removal** (b) Date thereof **12-24-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Madison, Illinois**

18. (a) Signature of funeral director **John L. Sedlacek**

(b) Address **Madison, Ill.**

19. (a) **DEC 24 1947** (b) **J. L. Sedlacek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **23** year **1947** hour **6** minute **40** P. M.

21. I hereby certify that I attended the deceased from **Dec. 3**, 19**47**, to **Dec. 23**, 19**47** that I last saw him alive on **Dec. 23**, 19**47**; and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinomatosis, general**
Site not known

Due to **352**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **As above**

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 **(1)**

23. Signature **F. L. Bradley** (M. D. or other)

Address **Barnes Hospital** Date signed **12/24/47**

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

MOTHER FATHER

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

John T. Sedlach

Licensed Embalmer No. *3747*

P. O. Address

Madison, Ill.

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.