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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 11 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1897

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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: 2013 MENARD
(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 000

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2013 MENARD 1
23 (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME CYRIL BACIK

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of ~~husband~~ or wife KATE

6. (c) Age of ~~husband~~ or wife if alive 70 years

7. Birth date of deceased MAR. (Month) 15 (Day) 1878 (Year)

8. AGE: Years 69 Months 11 Days 8 If less than one day hr. min.

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

10. Usual occupation CITY PARK EMPLOYEE

11. Industry or business

FATHER
12. Name JOHN BACIK
13. Birthplace (City, town, or county) AUSTRIA (State or foreign country)

MOTHER
14. Maiden name MAGDALENE FALTA
15. Birthplace (City, town, or county) AUSTRIA (State or foreign country)

16. (a) Informant KATE BACIK
(b) Address 2013 MENARD

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 26 1948 (Month) (Day) (Year)
(c) Place: burial or cremation RESURRECTION CEM

18. (a) Signature of funeral director Thomas Kate & Son
(b) Address 2906 GRAVOIS

19. (a) FEB 24 1948 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 23 year 1948 hour 8 minute A.M.

21. I hereby certify that I attended the deceased from 3-10, 1941, to 2/23, 1948; that I last saw him alive on 2/22, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lt. cerebral apoplexy	3 Days
Due to: Cardio vascular renal syndrome	8 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature [signature] (M. D. or other)
Address 3804 Wilmington Av. Date signed 2/23/48

(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 Leo J. Budde

Licensed Embalmer No. 3989

P. O. Address St. Louis, 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.