

S. No. 304
M-10-47
y. 5-17-39
I 3904

#825

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED MAY 15 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14565

Registrar's No. 4239

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, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis City Hospital - Max C. Starkloff
(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 Mad
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1804a Menard Street
Memorial 23 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

MATTHEW RAIC (RAICH)

3. (b) If veteran, name war _____

3. (c) Social Security No. 490-12-1341

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Raic 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased February 16-1892
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Heel Finisher

11. Industry or business

MOTHER FATHER { 12. Name Nicholas Raic
13. Birthplace Jugoslavia
(City, town, or county) (State or foreign country)
14. Maiden name Kate Bogdonovich
15. Birthplace Jugoslavia
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Raic
(b) Address 1804a Menard Street

17. (a) Burial (b) Date thereof 5-7-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection

18. (a) Signature of funeral director Mayfield and Co
(b) Address 1926 Allen Avenue

19. (a) MAY 5 1948 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th
year 1948 hour 4 minute 55 A.M.

21. I hereby certify that I attended the deceased from 4/28/48
_____, 19____, to May 4th, 19____
that I last saw him in alive on May 4th, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis ?
Duration _____

Due to _____

Due to _____

Other conditions 1/3
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
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) _____
(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)
(c) Means of injury _____

23. Signature J. F. Bredek (M. D. or other) M.D.
Address 1515 Lafayette Date signed 5/4/48

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.....

..... Me, Registered Apprentice No.....
working under my personal supervision.

Signed..... Benj. L. 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.