

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

31494

State File No.

FILED OCT 9 1948

Registration District No. **318**

Primary Registration District No.

Registrar's No. **8521**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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 2 days
28 years (Specify whether years, months or days)

In this community 0 years, months or days

3. (a) PRINT FULL NAME PAUL UHLIAR

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. Widower

6. (b) Name of husband or wife. Unknown 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased. December 28th, ?
(Month) (Day) (Year)

8. AGE: Years 49 Months - Days - If less than one day hr. - min. -

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

10. Usual occupation nil

11. Industry or business.

12. Name Martin Uhliar

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

14. Maiden name Anna Powatski

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital.

17. (a) Anatomical Board (b) Date thereof SEP 30 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) SEP 30 1948 (b) J. J. Bink
(Date received local registrar) (Registrar's signature)

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. Memorial (If rural, give location) 1421 Hogan

(e) Citizen of foreign country? 2/ (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 28th
year 1948 hour 1 minute 45 PM

21. I hereby certify that I attended the deceased from 8/26/48 to Aug. 28th
1948 and that death occurred on the date and hour stated above

Immediate cause of death Pulmonary Embolus

Due to Indurated Pt.

Due to Intestinal Hernia

Other conditions.
(Including pregnancy within 3 months of death)

Major findings:
Of operations Indurated Pt. Intestinal Hernia

Of autopsy Hernia

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? 0 (Specify type of place) (e) Means of injury 0

23. Signature E. J. Coxon, M.D. (M. D. or other) 0
Address 1515 Lafayette Date signed 8/30/48

WRITE PLAINLY--USE 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.....

Licensed Embalmer No.....

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.