

FILED AUG 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28475  
Registrar's No. 6860

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS Mo</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS 2149</u>		d. STREET ADDRESS (If rural, give location) <u>4973 ITASKA</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. ANTHONY'S Hosp. 19</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>STEFAN</u> b. (Middle) _____ c. (Last) <u>MIRKAY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 11 1950</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 1 1878</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 11 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PATTERN MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>QUICK MEAL STORE</u>		11. BIRTHPLACE (State or foreign country) <u>HUNGARY 8</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>AUGUST MIRKAY</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH KLOKAK</u>		14. NAME OF HUSBAND OR WIFE <u>REGINA MIRKAY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>489-03-6164 2</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>REGINA MIRKAY 4973 ITASKA</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>years.</u>	
19a. DATE OF OPERATION <u>8-2-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cholelithiasis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>58HX</u>			
22. I hereby certify that I attended the deceased from <u>April 10 1950</u> , to <u>Aug 11 1950</u> , that I last saw the deceased alive on <u>April 11 1950</u> , and that death occurred at <u>11:50 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>ALBERT J. GNADE</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>3606 Gravois St. Louis</u>		23c. DATE SIGNED <u>8-11-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG. 14 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>S-S. PETER + PAUL</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>	
DATE REC'D BY LOCAL REG. <u>AUG 12 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Fessler</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutei 2906 Gravois</u>			

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

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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed James C. Rice

Signed.....  
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 Travis

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.