

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042374

STATE FILE NUMBER
10766

FILED NOV 20 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 10766

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BOA City Hospital		Length of stay in lb	d. STREET ADDRESS (If outside, give location) #189 3737 LaSalle st. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ALEX VARGA		4. DATE OF DEATH Month Day Year 11-7-58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-1-1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) iron worker		10b. KIND OF BUSINESS OR INDUSTRY Iron	11. BIRTHPLACE (City and state or country) Hungary
13a. FATHER'S NAME Paul Varga		13b. MOTHER'S MAIDEN NAME Julia Ruda	14. NAME OF HUSBAND OR WIFE Lora Varga
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW2		16. SOCIAL SECURITY NO. 328-10-8351	17. INFORMANT Address Julia Varga, 3737 LaSalle st.
18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO (b) DUE TO (c) 490X			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James M Kelly (Degree or title) 3 Deputy Coroner		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 11-10-58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11-10-58	23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Aker, 1104 Manchester, St. Louis		25. DATE RECD. BY LOCAL REG. NOV 10 58	26. REGISTRAR'S SIGNATURE J. C. Smith m & B

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Plasencia M. Dillo*

Licensed Embalmer No. *4375*

P. O. Address *St. Charles, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. . . .

If this body is not embalmed, fact should be so stated above.