

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City St Louis

Registration District No. 791

File No. 82510

Primary Registration District No. 1003

Registered No. 8205

(NO. 1418 179th Ave)

St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME John Chroctowski

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Nov 19 1909
(Month) (Day) (Year)

AGE _____ yrs. 11 mos. 1 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) St Louis

NAME OF FATHER Theofil Chroctowski

BIRTHPLACE OF FATHER
(City or town, State or foreign country) Russia

MAIDEN NAME OF MOTHER Thopila Zendraszka

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theofil Chroctowski

(ADDRESS) 1418 179th Ave

Filed OCT 27 1910 Wheeler Bond
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Octob. 21 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Octob 19 1910, to Octob 21 1910, that I last saw him alive on Octob. 21 1910, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Gastric - Enteritis

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory Unknown
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. Galland M. D.
Octob 21 1910 (Address) 1519 Carr St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

Calvary

DATE OF BURIAL

Oct 22 1910

UNDERTAKER

Aug Brookland 1421 179

ADDRESS

