

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

PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City St Louis Mo (NO. 1443 IX 20<sup>th</sup>)

Registration District No. 701

File No. 28121

Primary Registration District No. 1003

Registered No. 7432

St. 4 Ward

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

FULL NAME Dr. Anthony J Grodzki

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug 4<sup>th</sup>, 1914  
(Month) (Day) (Year)

DATE OF BIRTH April 1, 1886  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 1, 1914, to Aug 4, 1914, that I last saw him live on Aug 3<sup>rd</sup>, 1914, and that death occurred, on the date stated above, at 2 P.M.

AGE 28 yrs. 4 mos. 4 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Phthisis Pulmonary  
tuberculosis.  
220 78 ✓

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

Contributory Pneumonia  
(SECONDARY) (Duration) 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) Washington Mo

NAME OF FATHER Valentine Grodzki

(Signed) J. Jacobson M. D.  
8, 4<sup>th</sup> 1914 (Address) 1833 Cass Ave.

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

MAIDEN NAME OF MOTHER Antonia Cieslick

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Martha Przyany

Where was disease contracted If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

(ADDRESS) 1625 Cass

PLACE OF BURIAL OR REMOVAL Cemetery DATE OF BURIAL Aug 6<sup>th</sup>, 1914

Filled AUG -5 1914 Max Starkloff REGISTRAR

UNDERTAKER Aug Bronsland ADDRESS 1421 17<sup>th</sup>

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.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

## PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

City St. Louis (NO. \_\_\_\_\_)REGISTRARS SHALL NOT RE-  
CEIVE A FEE FOR CERTIFICATES  
UNTIL THEY ARE COMPLETED AS  
PRESCRIBED BY LAW.

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

Registration District No. 791

File No. \_\_\_\_\_

Primary Registration District No. 1003Registered No. 7432

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number]FULL NAME Anthony J. Godzki

## PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH \_\_\_\_\_

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

AGE \_\_\_\_\_

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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) \_\_\_\_\_

NAME OF FATHER

BIRTHPLACE

(City or town, State or foreign country) \_\_\_\_\_

MAIDEN NAME

OF MOTHER \_\_\_\_\_

BIRTHPLACE

(City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

File # 12-1719141914REGISTRAR A. G. Madzki

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 4

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw him \_\_\_\_\_, 191\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Phthisis Pulmonary  
Tuberculosis  
Lobar Pneumonia  
(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory Pneumonia

(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Sign)

J. Jacobson M.D.  
1833 Casan\*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

DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

Original file, date \_\_\_\_\_

19141914

All information called for must be written on this Supplementary Certificate.

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