LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (NO. St Johns Hos St.; 25 Ward)

Registration District No. 791 File No. 36250

Primary Registration District No. 1003 Registered No. 9621

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

2 FULL NAME Frank Bartowski

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April (Month) 14 (Day) 1882 (Year)

7 AGE 36 yrs. 6 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer) Pittsburg Glass Co

9 BIRTHPLACE (City or town, State or foreign country) Austria

PARENTS

10 NAME OF FATHER Joe Bartowski

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

12 MAIDEN NAME OF MOTHER Frances Kop

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes Bartowski

(Address) Crystal City

15 Filed OCT 16 1918, 19 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 16 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191..., to ....., 191..., that I last saw h..... alive on ....., 191..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Shock & Injuries (Internal)

Crushed between two tables at Pittsburg Glass Works

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rudolph G. Vitt M. D.

Oct 16, 1918 (Address) Dorrier

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 1 ds. In the State 37 yrs. ..... mos. ..... ds.

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

Former or usual residence Crystal City Mo

19 PLACE OF BURIAL OR REMOVAL Crystal City Mo DATE OF BURIAL Oct 16, 1918

20 UNDERTAKER Nullen Und Co ADDRESS 4069 St Louis Ave

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

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ... St.;.....Ward)

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

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

.....(Month)..... (Day)....., 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

.....(Month)..... (Day)....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from .....,191....., to.....,191.....
that I last saw h.....alive on.....,191.....,
and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**

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