

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

Do not use this space.

13129

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **Josephine Hospital**)

File No.....
Registered No. **3429**
St..... Ward.....

2. FULL NAME

Anna Jarosik
(a) Residence No. **1916 Oregon** on St. **23** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred **32** yrs. **10** mos. **12** da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Divorced**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Louise Gillian**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 25-1904**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
22 10 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House-work**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo**
(STATE OR COUNTRY)

10. NAME OF FATHER **Frank Jarosik**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Bohemia**

12. MAIDEN NAME OF MOTHER **Anna Cepicky**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

14. INFORMANT **Anna Jarosik**
(Address) **1916 Oregon**

15. FILED **APR -9 1927** **Max B. Sturtevant** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 9 1927**

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above at.....

THE CAUSE OF DEATH WAS AS FOLLOWS: **7 15 P.**
General Septicemia
from an Abortion

CONTRIBUTORY (SECONDARY) **Homicide**

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH **Apr 1927**

8 DID AN OPERATION PRECEDE DEATH? DATE OF

9 WAS THERE AN AUTOPSY?

10 WHAT TEST CONFIRMED DIAGNOSIS? (Signed) **[Signature]** M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **S. S. Peter & Paul** DATE OF BURIAL **April 9 1927**

20. UNDERTAKER **Hor. E. Moydell** ADDRESS **1926 Allen**

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

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

