

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

Do not use this space.

791

17082

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No.....
Primary Registration District No.....
(No. *2119*) *MADISON*

File No.....
Registered No. *15049*
St..... Ward.....

2. FULL NAME

JULIA KALINOWSKI

(a) Residence. No. *2119 MADISON* St., *20* Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Frank Jr.</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Nov 29-1862</i>		
7. AGE	YEARS <i>64</i>	MONTHS <i>5</i>
	DAYS <i>29</i>	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Poland*

PARENTS

10. NAME OF FATHER <i>Albert Kipinski</i>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Poland</i>
12. MAIDEN NAME OF MOTHER <i>Unknown</i>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT *Frank J. Kalinowski*
(Address) *2119 Madison*

15. FILED *MAY 30 1927* *Mable Starckoff*
19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 28 1927*

17. I HEREBY CERTIFY, That I attended deceased from *May 27 1927* to *May 28 1927* and that I last saw her alive on *5-27-27* at *5:55 a.m.* and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastroenteritis Acute
120 B
114 B

CONTRIBUTORY (SECONDARY).....
(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH..... *Home*

DID AN OPERATION PRECEDE DEATH..... *no* DATE OF.....

WAS THERE AN AUTOPSY..... *no*

WHAT TEST CONFIRMED DIAGNOSIS..... *Remittent and pain*
(Signed) *J. H. Ford* M. D.
, 19 *(Address) 11973 Cass ave*

*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 <i>Cabney</i>	DATE OF BURIAL <i>May 31 1927</i>
20. UNDERTAKER <i>Central</i>	ADDRESS <i>1841 Cass</i>

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.

