

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

Do not use this space.

26052

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No. ....

Registered No. **7678**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **2751 N. Spring** St., ..... Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **15** yrs. .... mos. .... da. How long in U.S., if of foreign birth? yrs. .... mos. .... da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*male*

**4. COLOR OR RACE**

*white*

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

*married*

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

*Dec 13 - 1883*

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, .... hrs. or .... min.

*43*

*8*

*14*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

*Laborer*

(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)

*Russia*

**10. NAME OF FATHER**

*Alexander Guehniewicz*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Russia*

**12. MAIDEN NAME OF MOTHER**

*Anna Lubion*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*St. Petersburg*

**14.**

INFORMANT

(Address)

*Cherian City Hospital*

**15.**

FILED **AUG 29 1927**

*Marie S. Starkeoff*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

*Aug 27 1927*

**17.**

I HEREBY CERTIFY, That I attended deceased from *June 27*, 19*27*, to *Aug 27*, 19*27*, that I last saw him alive on *Aug 27*, 19*27*, and that death occurred, on the date stated above, at *8:30 a.m.*

THE CAUSE OF DEATH!\* WAS AS FOLLOWS:

*Chronic cardiac valvular disease  
Chronic myocarditis*

**CONTRIBUTORY (SECONDARY)**

*927  
931  
900*

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**18. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....**

**18. WAS THERE AN AUTOPSY?.....**

**18. WHAT TEST CONFIRMED DIAGNOSIS?.....**

(Signed) *Edmund R. Sheridan* M. D.  
*827.18* (Address) *City Hospital*

\*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**

**DATE OF BURIAL**

*Calvary Cem Aug 28 1927*

**20. UNDERTAKER**

**ADDRESS**

*Central Burial 1841 Pers*

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.

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

Juchnowicz