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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791 1003 File No. 23803

Township..... Primary Registration District No. ..... Registered No. 8136

City St. Louis (No. 834 Brooklyn St., ... St. ..... Ward)

2. FULL NAME Frank R. Mokanski

(a) Residence. No. 834 Brooklyn St., 26 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): ——

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ——

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 20-1927

7. AGE: Years ——; Months 6; Days 23; If LESS than 1 day, ... hrs. or ..... min.

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

PARENTS
10. NAME OF FATHER John Mokanski
11. BIRTHPLACE OF FATHER (CITY OR TOWN) East Hampton
(STATE OR COUNTRY) Mass.
12. MAIDEN NAME OF MOTHER Stephanie Turek
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lafarm
(STATE OR COUNTRY) Ill.

14. INFORMANT Stephanie Turek
(Address) 834 Brooklyn St.

15. FILED SEP 13 1927 19.. Ray C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 12th 1927

17. I HEREBY CERTIFY, That I attended deceased from September 10, 1927, to death, Sept. 12, 1927, that I last saw h... alive on September 10, 1927, and that death occurred, on the date stated above, at 7:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastro-Enteritis (due to errors of diet)
119B
(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 138
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical diagnosis
(Signed) Edwin Sauter, M. D.
Sept. 13, 1927 (Address) 1331 N. 7th St.

*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: Calvary — DATE OF BURIAL: Sept. 14th 1927

20. UNDERTAKER: Aug. Brockland L. & U. Co. — ADDRESS: 1427 N. 9th St.

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