

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

Do not use this space.

34985

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **10133**
St. Ward.....

2. FULL NAME

BENNY BRONISLAW TOCZYLOWSKI

(a) Residence. No. **1726 N. 12** St., **25** Ward.

(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 **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) **Nov. 12 1912**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
14 11 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **School**
(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) **St. Louis**

10. NAME OF FATHER

Adam Toczylovska

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Poland**

12. MAIDEN NAME OF MOTHER

Esther Moturcki

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Poland**

14.

INFORMANT (Address) **Adam Toczylovska**
1726 N. 12 St

15.

FILED **NOV 12 1927** **Man & Starkey** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **11-10-1927**

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..... **9 a**..... m.

THE CAUSE OF DEATH* WAS/AS FOLLOWS:

Shock & Injuries
Continued
Fell from Auto truck
Criminal
Carcinoma

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Wm Durr**

(Address) **Dup Corner**

*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 **Nov 12 1927**

20. UNDERTAKER

ADDRESS

Central **1841 Cass**

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.

100

REVEREND

100

100

CAUSE OF

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No.) St. Ward)

2. FULL NAME Benny Bronislaw Toczykowski

(a) Residence. No. St. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

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

7. AGE YEARS MONTHS DAYS 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) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 19 May 6 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-10 19 27

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock injuries (external) from auto truck
St. Louis County Mo.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? DID AN OPERATION PRECEDE DEATH? DATE OF WAS THERE AN AUTOPSY? WHAT TEST CONFIRMED DIAGNOSIS? (Signed)....., M. D. , 19 (Address)

*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 ADDRESS 19

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS PERMANENT P
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. FOREIGN BIRTH should state country of birth. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE & SIGNED BY LAW

SUPPLEMENTARY

S-34986