

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

A. Do not use this space.

35520

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City St. Louis (No. 5431) Robert St. _____ Ward _____

File No. _____
Registered No. **10709**
St. _____ Ward _____

2. FULL NAME

ELIZABETH TASZAREN

(a) Residence. No. 5431 Robert St., 7 Ward.

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. (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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 23 - 1901

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
26 | 6 | 1 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoe Worker
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer Muller Shoe Co

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) St. Louis

10. NAME OF FATHER

Joseph Tazsarek

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Poland

12. MAIDEN NAME OF MOTHER

Bronislawa Prokowska

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Poland

14.

INFORMANT (Address) Joseph Tazsarek
5431 Robert

15.

FILED 01 29 1927 Marie Starckoff
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 24 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1927 to Nov 24, 1927 that I last saw her alive on Nov 24, 1927, and that death occurred, on the date stated above, at 2 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY)

none (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, Home -

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Specify) Gram stain
11/26/27 Alan S. Good, M. D.
(Address) 3014 So. Jefferson

*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

Ouray Cem. 11-29-1927

20. UNDERTAKER

ADDRESS

Central Ind. Co. 184 Cass

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.

PERMANENT RECORD

Dr. T. M. L. K.