JAN 23 1928

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

Do not use this space.

38085

1. PLACE OF DEATH
County St. Louis — Registration District No. 789 — File No.
Township Central — Primary Registration District No. 6033 — Registered No. 355
City Overland Mo (No. 3309 Calvert Ave St. Ward)

2. FULL NAME MARY STANKIEWICZ
(a) Residence. No. 3309 Calvert 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 29 1868

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
59	9	2	

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 Peter Stankiewicz
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Poland
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

14. INFORMANT Walter Stankiewicz
(Address) 3309 Calvert Ave.

15. FILED 12/31, 1927 Rolla Bracy M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 31 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1927, to Dec 31, 1927 that I last saw her alive on Dec 31, 1927, and that death occurred, on the date stated above, at 2 a.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Pericarditis
90 B (Pericarditis)
112 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at Home
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) [signature] M.D.
12/31, 1927 (Address) 3500 N Grand

*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 Jan 3 1927

20. UNDERTAKER Central — ADDRESS 1841 Cass.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im

[illegible] Ha[illegible] [illegible]

[illegible] Gen[illegible] [illegible]
Offi[illegible] Gen[illegible] [illegible]