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

Do not use this space.

11160

1. PLACE OF DEATH

County ..... Registration District No. 797 ..... File No. 2990

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

City St. Louis (No. Emmonite St. Luke Hosp. ..... Ward)

2. FULL NAME JOHN SLIWINSKI

(a) Residence. No. 928 Goodfellow St., 5 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: 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: Marie Sliwinski

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 25 1886

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
41	2	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Shoe Repair
(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: Michael Sliwinski
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Poland
12. MAIDEN NAME OF MOTHER: Mary Bartman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Poland

14. INFORMANT: Mrs Mary Sliwinski
(Address) 928 Goodfellow

15. FILED MAR 17 1928, 19.. Max A. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 15 1928

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 3:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Thrombosis

94 P

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Coronary Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Mrs 92

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

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) R. S. Vitt, M. D.

16/11, 1928 (Address) Coo Ore

*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: Mon Mar 19-28

20. UNDERTAKER: Central
ADDRESS: 1841 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.