

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

Do not use this space.

15152

14885

File No. _____
Registered No. 4076
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... (No. *St. John's Hospital*)

2. FULL NAME

Josephine Dohensky
(a) Residence No. *51037 N. Kingshighway 7* 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 *Stanley Dohensky*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *9-15-1879*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 6 26

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *At home*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Poland*
(STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER *Casimir Hartwig*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs. N. Flynn*
(Address) *5037 N. Kingshighway*

15. FILED *R. B. 1924* *Gene C. Stankov*
19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr. 11 19 28*

17. I HEREBY CERTIFY, That I attended deceased from *March 12*, 19*28*, to *April 11*, 19*28* that I last saw him alive on *April 10*, 19*28*, and that death occurred, on the date stated above, at *5:35 a* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral thrombosis
Apoplexy *9288*
900 *9-11*
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Chronic tubercular disease*
Disease (duration) *5 (?)* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? *At home* mos. _____

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Physical examination*

(Signed) *A. R. Duffell*, M. D.

4/12/28 (Address) *1021 No. B. B. Mo. 13 Bldg. Mo. 13*

*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 Cem.* DATE OF BURIAL *4/14 19 28*

20. UNDERTAKER *Mc. Donnell & Co* ADDRESS *2117 E. Grand*

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.

