

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

Do not use this space.

19333

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City Adams (No. City Hosp #1) St. _____ Ward _____
 Registered No. 5769

2. FULL NAME

(a) Residence No. 819 Otwell St. 25 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** Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Brif

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt. 58 — — — —

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

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

10. NAME OF FATHER John Brif

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

12. MAIDEN NAME OF MOTHER Janina Jankowska

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

14. INFORMANT Francis Brif
 (Address) 819 Otwell St

15. FILED MAY 28 1928
W. C. Starling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 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 _____, T. A. _____, m. _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & lacerations
fall from roof
 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED 185
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? _____ **DATE OF** _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. W. Kerner M. D.
575 28 (Address) Dep. Coroner

*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** May 28 1928

20. UNDERTAKER Central **ADDRESS** 1841 6000

WRITE FULLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

X. 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.

