

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

No not use this space.

39044

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

*St. Louis* (N. *4755 Minnesota*)

File No.....

*11747*

Registered No.....

St.....

Ward)

**2. FULL NAME**

*Rose Witkowski*

(a) Residence. No.....

(Usual place of abode)

*4755 Minnesota*

*15* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX

*Female*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Widow*

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

*Widowed*

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

*Aug 27 1875*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

*53*

*3*

*21*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

*House Keeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

*At Home*

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

*Poland*

10. NAME OF FATHER

*Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Poland*

12. MAIDEN NAME OF MOTHER

*Zymanski*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Poland*

14.

INFORMANT (Address)

*John Witkowski  
4755 Minnesota*

15.

FILED

*Max E. Stanley  
REGISTRAR*

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

*Nov 29 1928*

17.

I HEREBY CERTIFY, That I attended deceased from

..... 19....., to ..... 19....., and that that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... *9:25 P* .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Coronary Sclerosis*

CONTRIBUTORY (SECONDARY)

*@ home  
my condition*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

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

WAS THERE AN AUTOPT? .....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. M. Ferner, M.D.*  
*10/11/28* (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

DATE OF BURIAL

*Cavary Cemetery Dec 5 1928*

20. UNDERTAKER

ADDRESS

*Central Ind. Co. 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.

RECORD WITH OBTAINING INFORMATION IS A PERMANENT RECORD

