

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

Do not use this space.

13165

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **1623 718**)

File No.....
Registered No. **3725**
St. Ward

2. FULL NAME FLORENCE GIEBRZINSKI

(a) Residence. No. **1623 718** St., **26** 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) **Child**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 29 1926**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	2	2	26	

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

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY)

10. NAME OF FATHER **Charles Giebrzinski**

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

12. MAIDEN NAME OF MOTHER **Ladislawa Gogulski**

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

14. INFORMANT **Charles Giebrzinski**
(Address) **1623 216 St. Louis**

15. FILED **27 19** **Max C. ...** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar. 25 1929**

17. I HEREBY CERTIFY, That I attended deceased from **3-25**, 19**29**, to **3-25**, 19**29**, that I last saw h. **h** alive on **3-25**, 19**29**, and that death occurred, on the date stated above, at **9:15** a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Convulsions **63**
86
(duration) yrs. mos. **1** ds.

CONTRIBUTORY **Rickets**
(SECONDARY) (duration) **1** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **St. Louis**
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **E. F. Sassin** M. D.
3-26 1929 (Address) **1701 Park Ave.**

*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 **Coburn** DATE OF BURIAL **Mar. 27 1929**

20. UNDERTAKER **Central** ADDRESS **1841 Cass.**

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

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.

3523 *Lepidoptera*