

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

Do not use this space.

16512

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **19400**)

**City 1003**

File No.....

Registered No. **4610**

St. Ward)

**2. FULL NAME**

(a) Residence. No. **1201 210** St. **25** Ward.

Length of residence in city or town where death occurred **19** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**4 MEDICAL CERTIFICATE OF DEATH**

3 SEX **male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 18 1929**

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

17. I HEREBY CERTIFY, That I attended deceased from **Mark W. Sheridan** on **April 18 1929**, and that I last saw him alive on **April 18 1929**, and that death occurred, on the date stated above, at **10:10 a.m.**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb 24 - 1870**

THE CAUSE OF DEATH\* WAS AS FOLLOWS: **Cellulitis of face (streptococci) followed by pericardial effusion**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**19 1 25**

CONTRIBUTORY (SECONDARY) **91 E** (duration) ..... yrs. .... mos. .... ds.  
**194 E** (duration) ..... yrs. .... mos. .... ds.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Shoemaker**  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

18. WHERE WAS DISEASE CONTRACTED

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

IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER **Valentine Cieszka**

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

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

WAS THERE AN AUTOPSY?.....

12. MAIDEN NAME OF MOTHER **Frances Kowalewski**

WHAT TEST CONFIRMED DIAGNOSIS?

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

(Signed) **Edmund R. Sheridan**, M. D.

14. INFORMANT **Becky W. Sheridan**  
(Address)

\*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.

15. APR 21 1929 FILED..... 19..... REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Cemetery** DATE OF BURIAL **April 22 1929**

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.

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

86

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Peluzka