

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

Do not use this space.

29637

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City..... (No. City Hospital #1)

File No.....  
 Registered No. 8795  
 St. St. Louis

**2. FULL NAME** JOSEPH WIELGOS

(a) Residence. No. 2018 So 12 St., 23 Ward.

(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 Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 16, 1908

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
21 | 4 | 6 |

**8. OCCUPATION OF DECEASED**

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

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

10. NAME OF FATHER Xavier Wielgos

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

12. MAIDEN NAME OF MOTHER Jeka Garnik

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

14. INFORMANT Xavier Wielgos  
 (Address) 2018 So 12 St

15. FILED 19 Nov 23 1929 REGISTER

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 27 1929

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., and that I last saw him alive on ..... 19....., and that death occurred, on the date stated above, at ..... 6:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral apoplexy  
 (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) Non Traumatic  
 (duration) ..... yrs. .... mos. .... ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. P. Hurley M.D.

\*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

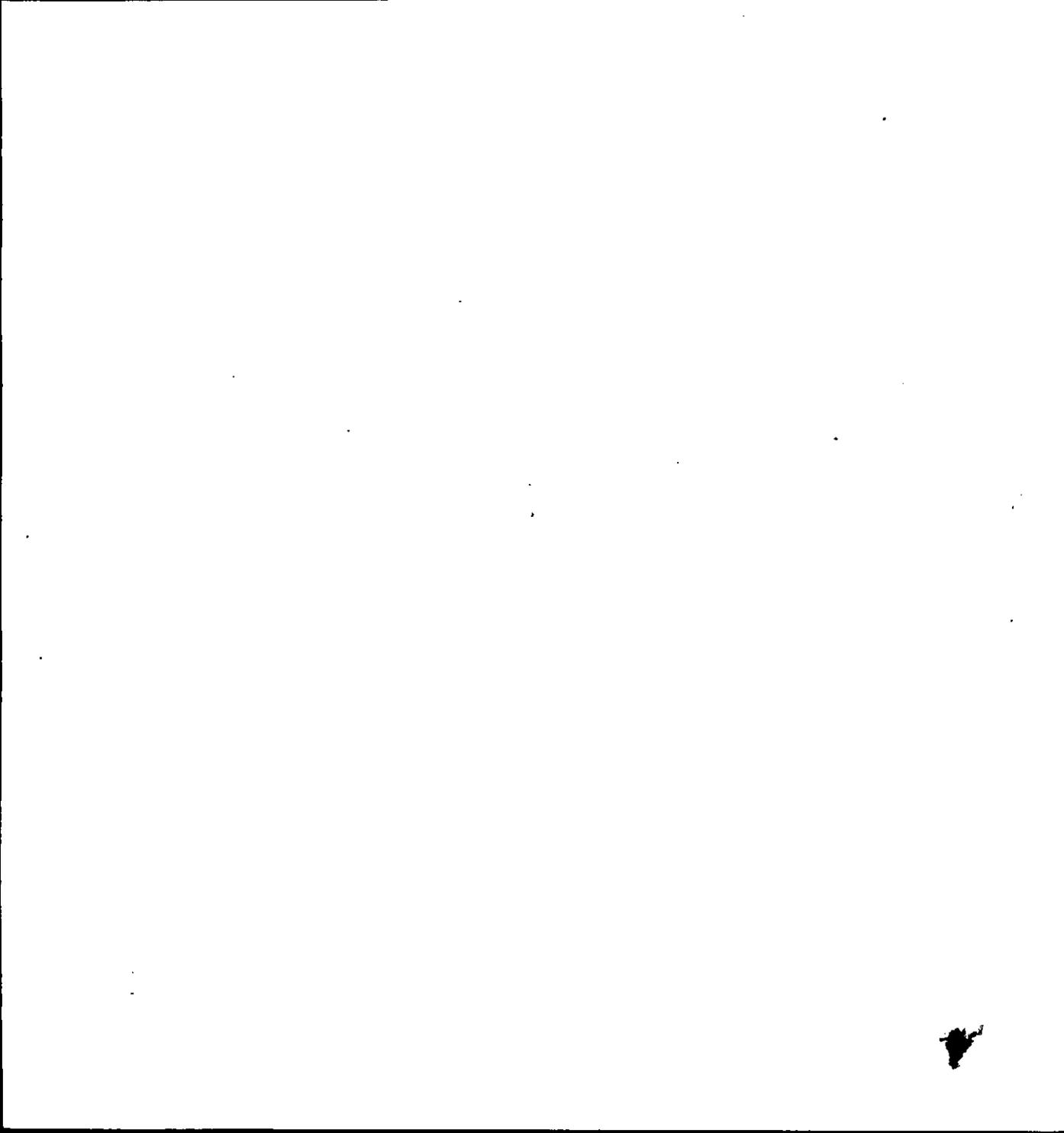
Burial Aug 31 1929

20. UNDERTAKER ADDRESS

Central 1841 6th St

11-8-29

29



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis  
Township St. Louis  
City St. Louis (No.           )

Registration District No. 791  
Primary Registration District No. 1003

File No.             
Registered No. 8995  
St.            Ward           

**2. FULL NAME**

Joseph Willgoos

(a) Residence. No.            St.            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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (with the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 16 - 1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
21 8 11

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work            (duration) yrs. mos. ds.  
(b) General nature of industry, business, or establishment in which employed (or employer)            (duration) yrs. mos. ds.  
(c) Name of employer           

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

10. NAME OF FATHER           

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

12. MAIDEN NAME OF MOTHER           

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

14. INFORMANT (Address)           

15. FILED           , 19            REGISTRAR           

**MEDICAL CERTIFICATE OF DEATH**

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17. I HEREBY CERTIFY That I attended deceased from            to           , 19            that I last saw h            alive on           , 19           , and that death occurred, on the date stated above, at            m.

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           (duration) yrs. mos. ds.

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

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH           

DID AN OPERATION PRECEDE DEATH? DATE OF           

WAS THERE AN AUTOPSY?           

WHAT TEST CONFIRMED DIAGNOSIS?           

(Signed)           , M. D.

. 19 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL            19           

20. UNDERTAKER ADDRESS           

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
CAUSE OF DEATH in plain terms, so that it may be properly classified.

SUPPLEMENTARY

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