

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

Do not use this space.

32557

**1. PLACE OF DEATH**

County..... Registration District No. 79  
Township..... Primary Registration District No. 1000  
City St. Louis (No. City Hospital) (St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_  
Registered No. 9665

**2. FULL NAME** Nancy B. (Nackowski) Washowski  
(a) Residence. No. 1436 N 14 St. 25 Ward. (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 48 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) Jan 1 - 1887

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
48 8 26

**8. OCCUPATION OF DECEASED**  
(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) 95  
(c) Name of employer

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

**10. NAME OF FATHER** Nancy Nackowski

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

**12. MAIDEN NAME OF MOTHER** Marie Barkhoff

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

**14. INFORMANT** (Address) City Hospital

**15. FILED** 23 1925 Marie Barkhoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

**17. I HEREBY CERTIFY**, That I attended deceased from Aug 15 to Sept 27 1929  
that I last saw him alive on Sept 27 1929 and that death occurred, on the date stated above, at 4:05 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chr Myocarditis & Decompensation & auricular fibrillation  
(duration) 3 yrs. 9 mos. ds.

**CONTRIBUTORY** none  
(SECONDARY) (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED** 1611 2 Dear  
IF NOT AT PLACE OF DEATH.

**DID AN OPERATION PRECEDE DEATH?** no DATE OF \_\_\_\_\_

**WAS THERE AN AUTOPSY?** no

**WHAT TEST CONFIRMED DIAGNOSIS?** Electrocardiogram  
(Signed) B Margulies M. D.

(Address) City Hospital

\*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** Cabany **DATE OF BURIAL** Oct 10 1929

**20. UNDERTAKER** Aug Brockland & Co **ADDRESS** 1421 N. 9th

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.

Nachweise.