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.

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

Do not use this space.

2755

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 190

City St. Louis Mo. (No. Deaconess Hosp. St. ..... Ward)

2. FULL NAME Arthur N. Wassilak

(a) Residence. No. 8240 St Charles Rock Rd. St., 11 Ward. St. Louis Co. Mo
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 2 - 1924

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

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

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

PARENTS

10. NAME OF FATHER Frank Wassilak

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

12. MAIDEN NAME OF MOTHER Louise Schmidt

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

14. INFORMANT Louise Wassilak
(Address) 8240 St Charles Rock Rd

15. FILED JAN 7 1930 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 1930

17. No Physician in Attendance
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 12 10 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation of Heart
82A
75B
following Cerebral Haemorrhage
(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? Yes
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Wm V Dever M.D.
1/7, 1930 (Address) 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 Staunton Ills
DATE OF BURIAL Jan 7 1930

20. UNDERTAKER Hy Leidner Und Co.
ADDRESS 1417 N. Market So