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

Do not use this space.

6918

File No. 1774

Registered No. 1774

Registration District No. 1003

Primary Registration District No.

1. PLACE OF DEATH

County

Township

City St. Louis (No. City Hospital St. Ward)

2. FULL NAME Mike Mosart ‡ Mick Soski

(a) Residence. No. 1402 Ohio St. 25 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 18 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) Nov Dunn

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
abt.	49			

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)
(c) Name of employer Odd jobs

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Poland

PARENTS

10. NAME OF FATHER Philip (Mosart) Soski

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

12. MAIDEN NAME OF MOTHER Marie Nov Dunn

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

14. INFORMANT E Rosar
(Address) City Hospital

15. FILED, 19 Mark C Fahey REGISTRAR

MEDICAL CERTIFICATE OF DEATH 2

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1930 to Jan 16 1930 that I last saw him alive on Jan 16 1930 and that death occurred on the date stated above, at 5:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lung Abscess
Non Tubercular from
Infection cause unknown (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 114B 10701 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Carl Hoot M. D.

1/17, 1930 (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 Calvary Cemetery — DATE OF BURIAL Feb 20 1930

20. UNDERTAKER Central Und Co — 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

Joski
Juosak.