

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

Do not use this space.

14802

1. PLACE OF DEATH

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

791
1008

Registration District No.....
Primary Registration District No.....

File No.....
Registered No. *4212*
St..... Ward.....

2. FULL NAME *JOSEPH-M. MUSHINSKI*

(a) Residence, No. *2501- DODIER* St. *20* 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Nov 6-1892</i>		
7. AGE	YEARS	MONTHS
	<i>37</i>	<i>4</i>
		18
		IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Moulder*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Noten Booked Supply*

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

10. NAME OF FATHER *Stales Mushinski*

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

12. MAIDEN NAME OF MOTHER *Not known*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Not known*

14. INFORMANT *Joseph Kaminski* (Address) *P.S.O. Dodier*

15. FILED *1937* *May 2* *Harley* REGISTER

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-24-1930*

17. I HEREBY CERTIFY, That I attended deceased from *3-29-* 19*30*, to *4-23-* 19*30* that I last saw h.l.m. alive on *4-23-* 19*30*, and that death occurred, on the date stated above, at *3:25 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11A BRONCHO-PNEUMONIA
107A

CONTRIBUTORY (SECONDARY) *LA GRIPPE* (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? *NO* DATE OF

WAS THERE AN AUTOPSY? *N.O.*

WHAT TEST CONFIRMED DIAGNOSIS *SYMPTOMS*

(Signed) *Joseph M. Naurocki* M. D.
4-25-1930 (Address) *1430 N-9th St.*

*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 *Cabray* DATE OF BURIAL *April 28 1930*

20. UNDERTAKER *Central* ADDRESS *1841 Com*

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.

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