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.

14819

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 4229

City St. Louis (No. ISOLATION HOSPITAL St. 24 Ward)

2. FULL NAME Dorothy Grzyb Grzyb

(a) Residence. No. 1205 Howard St., 26 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 6 mos. 8 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)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 18 — 1925

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	4	6	8	

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

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

PARENTS

10. NAME OF FATHER Walter Grzyb
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Poland
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Stella Lada
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Poland
(STATE OR COUNTRY)

14. INFORMANT L. Kroner
(Address) ISOLATION HOSPITAL

15. FILED FEB 28 1930 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-26 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-24, 1930, to 4-26, 1930 that I last saw her alive on 4-26, 1930, and that death occurred, on the date stated above, at 6:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diphtheria, Pharyngeal & Laryngeal
10
93A (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Acute myocarditis
(duration) ..... yrs. ..... mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) B. Kubbiel M.D.
4-27, 1930 (Address) ISOLATION 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 — DATE OF BURIAL April 29 1930

20. UNDERTAKER Aug Brockland L&U Co — ADDRESS 1421 N. 9 St.