

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

Do not use this space.

21029
~~21128~~

1. PLACE OF DEATH

County _____ Registration District No. 701
 Township _____ Primary Registration District No. 1003
 City St Louis (No. 4066 Maple) _____ St. _____ Ward _____

File No. _____
 Registered No. 5863

2. FULL NAME ANTONETTE BUKO WSKY

(a) Residence. No. 4066 Maple St. 11 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 18-1872

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>58</u>	<u>1</u>	<u>27</u>		

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

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

10. NAME OF FATHER Stephan Bogucki

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

12. MAIDEN NAME OF MOTHER Margalene Puchalski

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

14. INFORMANT Mathew Bykowski
 (Address) 4066 Maple St

15. FILED 27 1939 May 10 Starkley
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 15 1930

17. I HEREBY CERTIFY, That I attended deceased from MARCH 15, 1930 to JUNE 15, 1930, that I last saw her alive on 10 A.M. 6-15-1930, and that death occurred, on the date stated above, at 11:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CARCINOMA OF
U6B STOMACH
111B

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Terminal Pneumonia
RT. LOWER LOBE (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

IF IN OPERATION EXCEEDS DEATH DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? X Ray

(Signed) Frank Miller, M. D.

(Address) 1111 E. 19th St. St. Louis, Mo.

*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 Cobray DATE OF BURIAL June 14 1930

20. UNDERTAKER Cobray 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

Dr. F. J. W. Miller

Dr. Miller
418 St. Francois &
Immunity Club Bld.