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

Do not use this space.

12494

**1. PLACE OF DEATH**

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

File No. ..... Registered No. 3810

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

22379

**2. FULL NAME** Mary Kaszulowski

(a) Residence. No. 1317a Sarsfield (rear) St. 21 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 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) |
|---|---|---|
| female | white | married |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| About | 64 | | | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 235
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 10

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Hospital Information Grace Kapp
(Address) City Hospital

15. FILED ..... 19.. Max C. Starkeby REGISTRAR

**MEDICAL CERTIFICATE OF DEATH** 2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 25th 1931

17. I HEREBY CERTIFY, That I attended deceased from Mar. 24th, 1931, to Mar. 25th, 1931, that I last saw her alive on Mar. 25th 1931, and that death occurred, on the date stated above, at 2.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Myocarditis
TBC
95A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Auricular Fibrillation
(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? Refused (1)
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Jerome [illegible] M. D.
3/25, 1931 (Address) City Hosp

*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 | DATE OF BURIAL |
|---|---|
| Calvary Cem. | Mar 29 1931 |
| **20. UNDERTAKER** | **ADDRESS** |
| Central Ind C | 1841 Cass |

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

Kaszulooski