

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. 797

Township.....

Primary Registration District No. 103

City, St. Louis (No.)

File No. 29655
Registered No. 8688
St. Ward)

2. FULL NAME

GEORGE JULIANOSKI

(a) Residence, No. 3143rd Meade St., 15 Ward.

(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 Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17 - 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 1 21

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

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

10. NAME OF FATHER John Julanoski

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

12. MAIDEN NAME OF MOTHER Antonina Ogola

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

14. INFORMANT Anna Julanoski
(Address) 3143rd Meade St.

15. FILED AUG 11 1931 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 8 1931

17. W. J. Jensen, M.D. HEREBY CERTIFY, That I attended deceased from

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 4:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Asphyxiation, due to
Gas Poisoning
195 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Whether accidental
or intentional not explained (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? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. J. Jensen M.D.

8/10 1931 (Address) Dep. Coroner

*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 Cabary DATE OF BURIAL August 13 1931

20. UNDERTAKER Contel 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 PRINTING, WITH UNFADING INK---THIS IS A PERMANENT RECORD

