

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

Do not use this space.

30008

1. PLACE OF DEATH

County.....
Township.....
City..... (No. *City Hosp #1*)

Registration District No. *791*
Primary Registration District No. *1013*

File No.....
Registered No. *9069*
St..... Ward.....

2. FULL NAME

FRANK ZECZITOWSKI
(a) Residence. No. *4407 Louisiana 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 *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 4 - 1864*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 19 18

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

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

10. NAME OF FATHER *Frank Zeczowski*

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

12. MAIDEN NAME OF MOTHER *Joe Ruchalski*

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

14. INFORMANT *Mrs Estelle Riefer*
(Address) *4407 Louisiana St*

15. FILED *AUG 20 1931* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 22 1931*

17. *No Physician Attended*
I HEREBY CERTIFY That I attended deceased from 19..... to 19.....
that I last saw h..... alive on and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hypostatic Pneumonia following Dislocation of Left Sternum, Pleural Articulation, caused by fall to floor of residence (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *accident 106A*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *194B*
IF NOT AT PLACE OF DEATH *111B*

DID AN OPERATION PRECEDE DEATH? DATE.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *J. W. Keener*, M.D.
874 1931 (Address) *Bye Corner*

*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 *S. St. Peter & Paul* DATE OF BURIAL *Aug 26 1931*

20. UNDERTAKER *Centra* 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.

