

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

Do not use this space.

32579

1. PLACE OF DEATH

County.....

Registration District No. 201

Township.....

Primary Registration District No. 1033

City St. Louis (No. 1604 W. 17 & St)

File No.

Registered No. 9391

St. Ward)

2. FULL NAME ANNA SLAWSKA

(a) Residence. No. 1604^a W. 17 St. 26 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24 - 1866

7. AGE YEARS MONTHS DAY IF LESS THAN 1 day, hrs. or min.
65 3 12

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Poland

PARENTS

10. NAME OF FATHER Joe. Maseyok

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Gyma Swaronska (Address) 1604 W. 17

15. FILED SEP - 7 1931 Max E. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 5 1931

17. I HEREBY CERTIFY, That I attended deceased from May 8 1931 to Sept 5 1931, that I last saw her alive on July 20 1931, and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131
936
myocarditis chronic
doublet (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) the nephritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH 131

DID AN OPERATION PRECEDE DEATH? no DATE OF:

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Robert O. Sanders M. D.

. 19 (Address) 1427 N 15

*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 Sept 8 1931

20. UNDERTAKER Central 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. Robert O. Sanders

