

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *W. John Hospital* (No.....)

Registration District No. *791*  
Primary Registration District No. *1003*

File No. *2825*  
Registered No. *529*  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. *4740 Michigan* 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Casimir Cichocki</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Sept 2 - 1894</i>		
7. AGE	YEARS <i>37</i>	MONTHS <i>4</i>
	DAYS <i>12</i>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>235</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>House wife</i>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St Louis</i>		
MOTHER	13. NAME <i>Michael Olozinski</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Poland</i>	
	15. MAIDEN NAME <i>Antonia Jablonski</i>	
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Poland</i>		
17. INFORMANT <i>Casimir Cichocki</i> (ADDRESS) <i>4740 Michigan</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Cadray</i> DATE <i>Jan 18 1932</i>		
19. UNDERTAKER <i>Central Milk Co</i> (ADDRESS) <i>7844 Cass St</i>		
20. FILED 19 <i>Max C. Stork</i> Registrar		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 14*, 19*32*

22. I HEREBY CERTIFY That I attended deceased from *June 21*, 19*30*, to *January 14*, 19*32*

I last saw h. or alive on *January 13*, 19*32* Death is said to have occurred on the date stated above, at *8:20 a.m.*

The principal cause of death and related causes of importance were as follows:

*Myocarditis Acute*  
*Intra ventricular clot*  
*Pulmonary infarct*  
*Chl. interstitial nephritis*  
Other contributory causes of importance:  
*Myelitis acuta*  
*Alphilitis hepatis*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? *Autopsy* Was there an autopsy? *yes*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *no*  
If so, specify \_\_\_\_\_

(Signed) *W. S. Pranger*, M. D.  
(Address) *705 N. Kings Highway*  
*St Louis Mo.*

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

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.

Dr. [unclear] [unclear]  
Fo. 2571

79 [unclear] [unclear]  
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