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

Do not use this space.

3532

1. PLACE OF DEATH
County St Louis — Registration District No. 1170 — File No.
Township Central — Primary Registration District No. 6248 H — Registered No. 11
City Richmond Hts (No. St Mary's Hospital St. Ward)

2. FULL NAME Steve Lewaski
(a) Residence. No. 925 Washington Ave. Ward. Madison Ill.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U.S., if of foreign birth? 25 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~~ Mary Lewaski

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

7. AGE — YEARS: 38 — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Austria

PARENTS
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): unknown

14. INFORMANT Mary Lewaski
(Address) Madison, Ill.

15. FILED 1/22 1934 Gertrude Porter, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/22/34 1934

17. I HEREBY CERTIFY, That I attended deceased from 1-14/34, 19..., to 1/22/34 19..., that I last saw ~~b~~ alive on 1/22/34, 19..., and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr. Myocarditis
Ca Pancreas
(duration) 1 mos. ds.

CONTRIBUTORY (SECONDARY) Nephritis
Cirrhosis Liver
(duration) yrs. 4 mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Dr. James F. Hode M.D.
1/22/34 (Address) 1004 Mo Theatre Bldg

*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: Sunset Burial Park ~~Madison Illinois~~ — DATE OF BURIAL: Jan 24 1934

20. UNDERTAKER: Francis J. Lahey, St Louis, Mo — ADDRESS: Madison Ill.

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.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: St Louis — Registration District No.: 1170 — File No.:

Township: Kinloch — Primary Registration District No.: 62784 — Registered No.: 11

City: Richmond Hts. — No.: St. Mary's Hospital — St.: — Ward:

2. FULL NAME Steve Lunicski

(a) Residence, No.: — St.: — Ward: — Madison Ill.
(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? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): M

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

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

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

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19

19. UNDERTAKER (ADDRESS)

20. FILED — 19 — Gertrude Porter, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/22, 1934

22. I HEREBY CERTIFY, That I attended deceased from ....., to ....., 19....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ....m.

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

Nephritis

Cirrhosis of Liver

Other contributory causes of importance:

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

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?
If so, specify

(Signed) ....., M. D.

(Address)

SUPPLEMENTARY

REGISTRARS SHOULD NOT REQUIRE A CERTIFICATE TO BE COMPLETED AS FAR AS POSSIBLE UNTIL ALL ITEMS ARE COMPLETED BY THE PHYSICIAN. 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.

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