

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.

MAR 5-1937

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. **791**
 Township Primary Registration District No. **1003**
 City **St. Louis** (No. **1621 Hogan Street**)
 en route City Hospital No. 1

File No. **8539**
 Registered No. **1994**
 St. Ward)

2. FULL NAME **Dennis Sienawski**

(a) Residence, No. **1621 Hogan Street** St. **26** Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **about 1887**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
xxx. 56

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Iron Worker**
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Spook Fndry.**
 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) **Poland.**

13. NAME **Gregory Sienawski**

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

15. MAIDEN NAME **Catherine ?**

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

17. INFORMANT **Basil Sienawski**
 (ADDRESS) **4640 Michigan**

18. BURIAL, CREMATION, OR REMOVAL
 PLACE **Calvary Cem.** DATE **Feb. 17-37**

19. UNDERTAKER **Central. U. Co.**
 (ADDRESS) **1841 Cass Ave.**

20. FILED **FR 16 1937**
J. Bredeck
 Registrar.

MEDICAL CERTIFICATE OF DEATH
 No physician in attendance.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 13 37.**

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at **8:30 A.M.**
 The principal cause of death and related causes of importance were as follows:

Abcess of Right Lung; due to Broncho-Pneumonia.
 Date of onset
10/10

Name of operation Date of
 What test confirmed diagnosis? 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 **Joseph M. Quinn**
 (Signed) **Deputy Coroner**
 (Address)

