

NOV 15 1937

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

36207  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
(b) Township ..... Primary Registration District No. **1003**  
(c) City **ST. LOUIS, MO.** (d) Street No. **CITY HOSP #1.** Registered No. **9784**  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? **35** yrs. mos. da.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

(a) Residence, No. **1437 N. 7<sup>TH</sup> STR** St. **25**  
(Usual place of abode, if no street address, write county or city) (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) **MARRIED**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **JULY 20<sup>TH</sup> 1879.**

7. AGE YEARS **58** MONTHS **2** DAYS **29.** If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **GEN. LABOR**  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) **1930** 11. Total time (years) spent in this occupation **17 YRS.**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **POLAND**

13. NAME **WALTER MACIAK**

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

15. MAIDEN NAME **DONT KNOW.**

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

17. INFORMANT **Catherine Maciak** (ADDRESS) **1437 N 7<sup>TH</sup> ST**

18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVARY** DATE **OCT 23<sup>RD</sup> 1937**

19. FUNERAL DIRECTOR **BROCKLAND UND. CO** (ADDRESS) **1827 HOGAN STR.**

20. FILED **OCT 21 1937** **J. F. Bredek** Local Registrar.

~~NO~~ MEDICIN CERTIFIED DATE OF DEATH **Oct 19 1937**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 19 1937**

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 **11:40 P.M.**

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

**Chronic Myocarditis**  
**93C**  
**Arteriosclerosis**

Other contributory causes of importance:

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? **4**  
If so, specify **Alfred Perry** (Signed) **Alfred Perry** (Address) **Alfred Perry**

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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STATEMENT BY LICENSED EMBALMER

I, John B. Brockland, Licensed Embalmer No. 93  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

A \_\_\_\_\_ L. E. \_\_\_\_\_  
No. \_\_\_\_\_ or by \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed John B. Brockland  
Licensed Embalmer No. 93

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**