

JAN 10 1938

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

42889  
Do not use this space.

791 /  
1003 /

11139  
Registered No.

1. PLACE OF DEATH  
(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City St/ Louis (d) Street No. City Hospital No.1 St.  
(e) Length of residence in city or town where death occurred 40 yrs. — mos. — ds. (f) How long in U. S., if of foreign birth? 40 yrs. — mos. ds.  
C. 10985 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Agnes Bednarkiewicz  
(a) Residence, No. 1416 North 20 St. 21  
(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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (writes the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF JOHN BEDNARKIEWICZ, April 21, 1868

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
69 7 9

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY, Poland

FATHER  
13. NAME JOSEPH SHABLEWSKI

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY, ID

MOTHER  
15. MAIDEN NAME DONT KNOW

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY, ID

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE DEC. 4<sup>th</sup> 1937

19. FUNERAL DIRECTOR (ADDRESS) BROCKLAND, UND. CO. 1827 HOGAN ST.

20. FILED DEC 3 1937 J. Bredek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/ 1/37 19

22. I HEREBY CERTIFY, That I attended deceased from 10/26/37 19 to 12/1/37 19. I last saw h. hen alive on 12/1/37 19. Death is said to have occurred on the date stated above, at 3.45m.p

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

Cerebral Thrombosis

Date of onset

Other contributory causes of importance:  
Generalized arteriosclerosis  
Atherosclerosis of myocardium

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?.....  
If so, specify Charles M. Jessico, M. D.  
(Signed) (Address) City Hospital No.1

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.

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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  
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.)**