

WRITE PLAINLY WITH UNODING 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.

REC'D MAY 10 1938

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

12992
Do not use this space.

791
1003

1. PLACE OF DEATH

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

Registered No. **3596**

2. PRINT FULL NAME William Kenski **520**

(a) Residence, No. 6154 Laura St. **7**
(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) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12/22/1861
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 3 24

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil
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)
11. Total time (years) spent in this occupation

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

FATHER 13. NAME Simon Kenski
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland

MOTHER 15. MAIDEN NAME Catherine Gachnowski
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland

17. INFORMANT (ADDRESS) Hosp. info. M. Williams City Hospital #1

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peter's DATE 4/18

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edith E. Gumbert 4234 Maple St.

20. FILED **APR 18 1938** J. D. Bredek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/16/38 1938

22. I HEREBY CERTIFY, That I attended deceased from 4/13/38, 1938, to 4/16/38, 1938.
I last saw him alive on 4/16/38, 1938. Death is said to have occurred on the date stated above, at 12:40 P.M.
The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage
Hypertensive heart disease
Date of onset
Other contributory causes of importance: None

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? No

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) W. M. M. M. M., M. D.
(Address) 1515 Lafayette

Em blank signed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.