

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.

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

8517
Do not use this space.

1. PLACE OF DEATH

(a) County 1 Registration District No. **791**
(b) Township 1 Primary Registration District No. **1003**
(c) City ST. LOUIS MO (d) Street No. 4941 DAVISON AV. 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.

2. PRINT FULL NAME

(a) Residence, No. 4941 DAVISON AV. St. 7 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 BARBARA		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT. 11TH 1863		
7. AGE	YEARS 75	MONTHS 4.
	DAYS 25	IF LESS than 1 day, hrs. min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LABOR	11. Total time (years) spent in this occupation 10 YRS
	9. Industry or business in which work was done, as saw mill, bank, etc. MAWNEY ELECTRIC	
	10. Date deceased last worked at this occupation (month and year) MCH 1930	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY	
	13. NAME JOSEPH SKREDYNSKI	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY	
	15. MAIDEN NAME JOHANNA STEMPA	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY	
17. INFORMANT (ADDRESS) Barbara Skredynski 4941 DAVISON		
18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE MCH 11TH 1930		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) BROCKLAND UND. CO 1827 HOGAN. STR.		
20. FILED MAR 9 1939 JO Brockland Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **MARCH 8TH 1939**

22. I HEREBY CERTIFY, That I attended deceased from **March 27**, 19**30**, to **Mar 8-19**, 19**39**
I last saw him alive on **Mar 7**, 19**39** Death is said to have occurred on the date stated above, at **1 P.** m.
The principal cause of death and related causes of importance were as follows:
Mar 27-1930
Cerebral Hemorrhage
Other contributory causes of importance:
Mar 5-39
Renarant Hemorrhage

Name of operation **None** Date of _____
What test confirmed diagnosis? **Cerebral** 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? **No**
If so, specify **Rudolph A. Abel**, M. D.
(Signed) _____ (Address) **4929 Davison Blvd.**

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 *Me,*

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

Signed *John B. Brockland*

Licensed Embalmer No. *93*

P. O. Address *ST. LOUIS MO.*

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.