REC'D JUL 12 1939

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

20437
Do not use this space.

1. PLACE OF DEATH
(a) County
(b) Township
(c) City St. Louis
Registration District No. 791
Primary Registration District No. 1003
Registered No. 5281
(d) Street No. City Hospital No. 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.
E 2990 6 24

2. PRINT FULL NAME Rose Orzel
(a) Residence, No. 1449 Chambers 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 (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 25, 1918

7. AGE ~~20~~ Years 20. Months 8. Days 17 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. SEWING
9. Industry or business in which work was done, as saw mill, bank, etc. BASE BALLS GRADY MFG. CO
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) St. Louis, Missouri

FATHER
13. NAME Stanley Orzel
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland

MOTHER
15. MAIDEN NAME Mary GASKA
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland

17. INFORMANT (ADDRESS) Hosp. Info M. Ke t

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE JUNE 15TH, 1939

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

20. FILED JUN 13 1939 J. F. Budeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/11/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 6/2/39, 19 6/11/39, 19 I last saw h... alive on 6/11/39, 19 Death is said to have occurred on the date stated above, at 5.20 m
The principal cause of death and related causes of importance were as follows:

Appendicial abscess — Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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) John H. Killian, M. D.
(Address) City Hospital No. 1

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. 53-R.O. 2.
50M-7-20-37
1 X12004

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2971

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.)