

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

530 JUL 12 1939 791
Registration District No. 1008

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 15
(d) Street No. 6025 Suburban
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Frank Domachowski 522

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 12, 1880.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 4 9 hr. _____ min.

9. Birthplace Poland
(City, town, or county) (State or foreign country)

10. Usual occupation painter

11. Industry or business ?

12. Name Anthony Domachowski

13. Birthplace Poland
(City, town, or county) (State or foreign country)

14. Maiden name Frances

15. Birthplace Poland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature M. Kent

(b) Address City Hospital No. 1

17. (a) Burial (b) Date thereof June 24/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.

19. (a) JUN 23 1939 (b) J. P. Brudick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month June day 21, 1939
year _____ hour 9.35 minute 00 M.

21. I hereby certify that I attended the deceased from 6/21/39, 19____ to _____, 19____;
that I last saw him alive on 6/21/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lung Abscess (non-tuberculous)
bronchiectases

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy Lung Abscess
Bronchiectases

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature William Sapsen (M. D. or other)

Address City Hospital No. 1 Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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 Joseph W. Clark
Licensed Embalmer No. 1661

P. O. Address 1125 Hodiament Ave.

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.