

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

24140
 Do not use this space.

AUG 11 1939

1. PLACE OF DEATH
 (a) County..... Registration District No..... **791**
 (b) Township..... Primary Registration District No..... **1003**
 (c) City **St. Louis** (d) Street No. **City Hospital** 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. **6413**

2. PRINT FULL NAME **Rose Weiss Cherry Wisniewski**
 (a) Residence, No. **1227a North 10th. Street** St. **25** (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 **Female** 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 **John Wisniewski**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept. 4th, 1886**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 10 / 5
 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. **Housewife**
 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** **7**
 FATHER
 13. NAME **Raymond Rietelski** **7**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Poland** **7**
 MOTHER
 15. MAIDEN NAME **Don't Know** **7**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Poland**
 17. INFORMANT (ADDRESS) **John Wisniewski**
1227a North 10th. Street
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE
Calvary Cemetery July 22, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) **General Funeral Home Inc**
2233 University Street.
 20. FILED **Jul 21 1939** *J. P. ...* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 19th, 1939**
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw h..... alive on _____, 19____, at _____ A.M. Death is said to have occurred on the date stated above, at _____:45 P.M.
 The principal cause of death and related causes of importance were as follows:
Aortic Stenosis;
Coronary Sclerosis (Cor Bovis.)
 Date of onset
 Other contributory causes of importance:
 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? **No**
 (If no, specify.....)
 (Signed) *James J. ...*, M. D.
 (Address) *James J. ...*

Sept. 4-1886

52-10-15

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.....

Edward H. Lockhart

....., Registered Apprentice No.

working under my personal supervision.

Signed *Edward H. Lockhart*

Licensed Embalmer No. *2502*

P. O. Address *Clayton 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.