

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33901**
Registrar's No. **8439**

Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH: **1008**
(a) County **1**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **DePaul Hospital**
(If not in hospital or institution, write street number or location) **2 days**
(d) Length of stay: In hospital or institution **Sept. 28, 1939**
(Specify whether
In this community **53 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **1**
(c) City or town **St. Louis** **7**
(If outside city or town limits, write "RURAL")
(d) Street No. **5516 Thrush**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **53 years** years.

3. (a) PRINT FULL NAME **Bruno Chaplicki**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **1**
year **1939** hour **6** minute **P** M.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Agnes** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **January 4, 1869**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9-28**, 1939, to **10-1**, 1939
and that death occurred on the date and hour stated above. **10-1**, 1939
that I last saw him alive on _____

8. AGE:	Years	Months	Days	If less than one day
	70	8	26	hr. _____ min. _____

Immediate cause of death **Cardiac Decomposition** Duration **41 days**
Due to **Cardiac Failure**
Due to _____

9. Birthplace **Poland** (City, town, or county) (State or foreign country)
10. Usual occupation **Molder** **7**

Other conditions **Hypertension** **5 yrs**
(Includes pregnancy within 3 months of death)

11. Industry or business **Retired**
12. Name **(?) CHAPLICKI** **7**
13. Birthplace **Poland** (City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **Poland** (City, town, or county) (State or foreign country)

Major findings:
-Of operations _____
Of autopsy _____

16. (a) Informant's own signature **B. Chaplicki**
(b) Address **5516 Thrush**

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

17. (a) **Burial** (b) Date thereof **Oct. 4, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary**
18. (a) Signature of funeral director **St. Louis' Funeral Home**
(b) Address **2205 St. Louis Ave.**

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? _____ (e) Means of injury **1**

19. (a) **OCT 3 1939** (b) **J. T. Pralick**
(Date received local registrar) (Signature)

23. Signature **A. F. Lerner** (M. D. or other) **W. D.**
Address **1259 N. Kingshighway** Date signed **10-1-39**

OCT 3 1939

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be extremely supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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 Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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