

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-30  
Form 1 1931

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38397

DEC 13 1939 791

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 10236

1. PLACE OF DEATH: 1007  
(a) County 3  
(b) City or town St. Louis  
(c) Name of hospital or institution: Groute City Hospital  
(d) Length of stay: \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
(a) State mo (b) County 1  
(c) City or town St. Louis 23  
(d) Street No. 1802<sup>nd</sup> Lafayette  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

In this community \_\_\_\_\_ years, months or days

8. (a) PRINT FULL NAME John Skisz 421

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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: Unknown  
(Month) (Day) (Year)

8. AGE: 64 Years Months Days If less than one day  
hr. min.

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant's name and signature Wanda  
(b) Address 5928 Washington St

17. (a) \_\_\_\_\_ (b) Date thereof 12-30-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Wanda  
(b) Address 2500 Rugby

19. (a) NOV 30 1939 (b) \_\_\_\_\_  
(Date received local registrar) (City, town, or county)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24  
year 1939 hour 7 minutes 50 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of Throat  
Due to \_\_\_\_\_

Due to 45

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Joseph M. Luman  
Address Deputy Coroner Date signed \_\_\_\_\_

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**