

Registration District No. **701** Primary Registration District No. _____

1. PLACE OF DEATH: **5000**
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Luthern Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 da** (Specify whether years, months or days)
In this community **20 yr.**

2. USUAL RESIDENCE OF DECEASED: **1**
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **8401 Reilly Ave.** (If rural, give location)
(e) If foreign born, how long in U. S. A. **47** years.

3. (a) PRINT FULL NAME **Grace M. Jasinski** **252**
3. (b) If veteran, name war **--** 3. (c) Social Security No. **--**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **12** day **19-**
year **1939** hour **11:30** minute _____ M.

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Martin** 6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **April 19 1884**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **12-8-**, 1939, to **12-19-**, 1939, that I last saw her alive on **12-19-**, 1939, and that death occurred on the date and hour stated above.

8. AGE: Years **55** Months **8** Days **1** If less than one day _____ hr. _____ min.

Immediate cause of death **Coronary Thrombosis**
Due to **Interstitital [Chronic] Nephritis**
Due to **Obesity**
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **none made**

9. Birthplace **Germany** (City, town, or county) (State or foreign country)
10. Usual occupation **house wife**
11. Industry or business **at home**
12. Name **Andrew Fialkowski**
13. Birthplace **Germany** (City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **Germany** (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature **Martin Jasinski**
(b) Address **8401 Reilly**
17. (a) **burial** (b) Date thereof **12-23-39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Park Lawn**
18. (a) Signature of funeral director **Fendler Und. Co.**
(b) Address **7420 Michigan**
19. **DEC 21 1939** (b) **J. J. [Signature]**
(Date received local registrar)

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) (e) Means of injury **1**
23. Signature **D. S. P. [Signature]** (M. D. or other) _____
Address **6006 Virginia** Date signed **12/21/39**

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.

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.....

Oleum E Gendle....., Registered Apprentice No. *186*
working under my personal supervision.

Signed *Wilson Collins*.....

Licensed Embalmer No. *3887*.....

P. O. Address *St. Louis, 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.