

Registration District No. 2000 Primary Registration District No. 791

1. PLACE OF DEATH:  
(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(c) Name of hospital or institution: City Hospital, #1  
(d) Length of stay: In hospital or institution 17 Days  
In this community 17 years, months or days

3. (a) PRINT FULL NAME Veronica Arcipowski  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife JOHN 6. (c) Age of husband or wife if alive No years  
7. Birth date of deceased 2 4 1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
45 11 8 14 hr. min.

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

10. Usual occupation House Wife

11. Industry or business 1

MOTHER FATHER { 12. Name Unknown 9  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph P. Arcipowski  
(b) Address 1321 Sarsfield Pl.

17. (a) Burial (b) Date thereof Jan. 22 40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director CENTRAL UND? CO  
(b) Address 1841 Cass Ave

19. (a) JAN 20 1940 (b) J. J. [Signature]  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St Louis 21  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1321 b Sarsfield  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 30 years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day 18,  
year 1940 hour 11:05 minute A. M.

21. I hereby certify that I attended the deceased from January 2, 19 40 to January 18, 19 40  
that I last saw her alive on January 18, 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Right Ovary with Peritoneal Metastasis  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Date signed 1/18/40

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

**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 Ray 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 with the above constitutes grounds for revocation of license.)**

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