

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 701

Primary Registration District No. 1003

Registrar's No. 750

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(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:  
St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 weeks  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

RURAL FEB 17 1940

USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 19  
(d) Street No. 4167 Delmar Blvd.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Jane Kolodziej 432

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Walter Kolodziej 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased December 10, 1897  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
42 1 13 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name John Kouranski

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

14. Maiden name Unknown  
15. Birthplace Unknown Poland  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Kolodziej X

(b) Address 4167 Delmar Blvd.

17. (a) Burial (b) Date thereof 1 27 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Church

18. (a) Signature of funeral director Central Funeral Home

(b) Address 1841 Cass Avenue.

19. (a) JAN 25 1940 (b) J. J. [Signature]  
(Date received from registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23  
year 1940 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan 1939  
\_\_\_\_\_ 19 \_\_\_\_\_ to Jan 23, 19 40  
that I last saw her alive on Jan 23, 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death Myelogenous Leukemia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 47  
(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 3604 [Address] Date signed 1/24/40

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

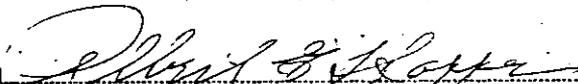
**STATEMENT BY LICENSED EMBALMER**

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. 297

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.**