

WRITE PLAINLY, WITH UNFADING INK...THIS IS A PERMANENT RECORD

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

FILED FEB 22 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

3989

1. PLACE OF DEATH

County Shannon Registration District No. 824  
Township Eminence Primary Registration District No. 5-1-1  
City (No. ) St. Ward

2. FULL NAME Peter P. Dominickowski

(a) Residence, No. St. Ward. (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/9/79

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
60 11 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT Geo W. Haynes (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Murrells Chapel DATE 2/9 1940

19. UNDERTAKER none (ADDRESS)

20. FILED 2-9- 1940 Frank Hyde MD Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/8 1940

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

No attending Physician  
Probably Pneumonia  
N. D. D.

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) ER Houston M. D.

(Address) Eminence Mo

RECEIVED

District Health Officer No. 5,

District File Number 240 225

Date Filed 2/6/40

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

3989

Do not use this space.

1. PLACE OF DEATH
- (a) County Shannon Registration District No. 824
- (b) Township Eminence Primary Registration District No. 6074 Registered No. \_\_\_\_\_
- (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_
- (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Peter P Dominikowski
- (a) Residence, No. Linna Mo. St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S
- 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_
- | 7. AGE | YEARS     | MONTHS    | DAYS     | If LESS than 1 day, _____ hrs. or _____ min. |
|--------|-----------|-----------|----------|--|
|        | <u>60</u> | <u>11</u> | <u>9</u> |  |
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_
- FATHER
13. NAME \_\_\_\_\_
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_
- MOTHER
15. MAIDEN NAME \_\_\_\_\_
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_
17. INFORMANT (ADDRESS) \_\_\_\_\_
18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19
19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_
20. FILED 2-8 1940 Frank Hyde MD Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-18 1940
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.
- I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.
- The principal cause of death and related causes of importance were as follows:
- | Date of onset |
|---------------|
|               |
- Other contributory causes of importance: \_\_\_\_\_
- Name of operation \_\_\_\_\_ Date of \_\_\_\_\_
- What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_
23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_
- Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_
24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) G. B. Houston M. D.  
 (Address) Eminence Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

