

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **4303**
Registrar's No. **1133**

Registration District No. **791** Primary Registration District No. _____

FILED MAR 22 1940

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: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 39 Days
(Specify whether _____)
In this community _____
years, months or days)

8. (a) PRINT FULL NAME John Wisniewski

3. (b) If veteran, name war none 8. (c) Social Security No. none

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

6. (b) Name of husband or wife Rosa 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 25, 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 10 7 hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Don't know

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Wisniewski
(b) Address 1609 North 20th Street

17. (a) Burial (b) Date thereof Feb. 5, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (d) Signature of funeral director Funeral Home

(b) Address 2233 University Street

19. (a) FFB (b) _____
(Date received by registrar) (Name of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 25
(If outside city or town limits, write "RURAL")
(d) Street No. 1227a North 10th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 30 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 2,
year 1940 hour 10:15 minute A. M.

21. I hereby certify that I attended the deceased from December 25, 1939 to February 2, 1940

that I last saw him alive on February 2, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Lobar Pneumonia
Due to Pneumococcus type

Due to _____

Other conditions Bacterial endocarditis
(Include pregnancy within 3 months of death)
meninges (both pneumococci)
Major findings _____
Of operation _____

Of autopsy same

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?

(a) Signature _____ (b) Means of injury _____
(Specify type of place) (M, D, or other)

(23.) Signature [Signature] (M, D, or other) _____
Address 1515 Lafayette Date 2/2/40

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

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.....

Edward J. Bockhorst....., Registered Apprentice No.....
working under my personal supervision.

Signed *Edward J. Bockhorst*

Licensed Embalmer No. *2502*

P. O. Address *Clayton, Md*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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