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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1940

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8688

Primary Registration District No.

Registrar's No. 2171

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: City Hospital, #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County x

(c) City or town St. Louis, 21
(If outside city or town limits, write "RURAL")

(d) Street No. 2322 Franklin Ave.,
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Marko Polyak

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

abt

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

10. Usual occupation Unknown

11. Industry or business Unknown

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Unknown (State or foreign country)

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

16. (a) Informant Ann Morrison
(b) Address City Hospital, #1

17. (a) (Burial, cremation, or removal) (b) Date thereof 3-15-40 (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cem.

18. (a) Signature of funeral director Wm. C. Moydell
(b) Address 1926 Allen Ave

19. (a) MAR 4 1940 (Date received local registrar) (b) J. B. Bachek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 11, year 1940 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from February 9, 1940 to February 11, 1940 that I last saw him alive on February 11, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to Rt Middle & Lower Lobes

Due to Pneumococcus #111

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. Wiere (M. D. or other)

Address 1515 Lafayette, Date signed 2/13/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.