

1881
No. 2
11-10-39
5-17-40
I XI

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12855

MAY 15 1940

791

1003

State File No. _____

Registrar's No. **3057**

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County C
(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 7 Days
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town ST LOUIS 20
(If outside city or town limits, write "RURAL")
(d) Street No. 2342 Howard st
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Stephie Sadowski 270

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 Single

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

7. Birth date of deceased July 14 1919
(Month) (Day) (Year)

8. AGE: Years 20 Months 8 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation none 7

11. Industry or business _____

MOTHER FATHER { 12. Name John Sadowski 7

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

14. Maiden name Iwardowska

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

16. (a) Informant John Sadowski
(b) Address 2342 Howard st

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

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director St. Louis Funeral Home
(b) Address 2205 St. Louis Ave

19. (a) APR 2 1940 (b) _____
(Date received local registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31,
year 1940 hour 8:05 minute P. M.

21. I hereby certify that I attended the deceased from March
25, 1940, to March 31, 1940,
that I last saw her alive on March 31, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart Disease

Due to _____

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 W. M. Pike (M. D. or other) _____
Address 1515 Lafayette, Date signed 4/1/40

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Albert G. Hoppa

Licensed Embalmer No. 2921

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.