

No. 2  
11-10-39  
-17-39  
X 21482

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13193

MAY 15 1940

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3395

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3243 A Montgomery  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(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. 3243 Montgomery  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME STANLEY BRONAKOSKI 652

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 494-09-4049

4. Sex MALE 5. Color or race WHITE 6. (a) Single widowed, married, divorced married

6. (b) Name of husband or wife ADELAIDE 6. (c) Age of husband or wife if alive 19 years

7. Birth date of deceased NOVEMBER 9 1919  
(Month) (Day) (Year)

8. AGE: Years 20 Months 5 Days 3 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace ZG MONT POLAND  
(City, town, or county) (State or foreign country)

10. Usual occupation unemployed

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

12. Name ZGONT BRONAKOWSKI  
13. Birthplace POLAND  
(City, town, or county) (State or foreign country)

14. Maiden name M. GACIOCH  
15. Birthplace POLAND  
(City, town, or county) (State or foreign country)

16. (a) Informant Zgmont Bronakowski  
(b) Address 3243 Montgomery

17. (a) Burial (b) Date thereof 4-16-40  
(Burial, cremation, or other) (Month) (Day) (Year)  
(c) Place: burial or cremation CALVARY CEMETARY

18. (a) Signature of funeral director CENTRAL FUNERAL HOME  
(b) Address 1841 CASS AVE

19. (a) APR 15 1940 (b) J. C. Creane  
(Date of local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12 year 1940 hour 10 minute 30 P M.

21. I hereby certify that I attended the deceased from April 9, 1940, to April 12, 1940, that I last saw him alive on April 12, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration 1 year

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

Other conditions Perirectal abscess 2 wks  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature J. C. Creane MD (M. D. or other) \_\_\_\_\_  
Address 2504 N. 14th St Date signed 4-19-40

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. Hopper*

Licensed Embalmer No. 2971

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.**