DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

27212

State File No.

FILED SEP 25 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 7108

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.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 Days (Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County

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

(d) Street No. 1924 Lincoln
(If rural, give location)

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

3. (a) PRINT FULL NAME Sylvester Janesky 5 20

3. (b) If veteran, name war No

3. (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 Veronica Janesky

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

7. Birth date of deceased August (Month) 15 (Day) 1879 (Year)

8. AGE: Years 61 Months 0 Days 6 If less than one day hr. min.

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

10. Usual occupation retired

11. Industry or business

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

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

16. (a) Informant's own signature Mary Majesky

(b) Address 1924 Lincoln Ave. E. St. Louis, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Belleville Illinois

18. (a) Signature of funeral director Herbert A. Kassly

(b) Address 315 Vandalia St. Collinsville, Ill.

19. (a) AUG 23 1940 (Date received local registrar) (b) J. B. Bathrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21 year 1940 hour 11 minute 58 A.M.

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

	Duration
Immediate cause of death: Carcinoma of esophagus	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 F. R. Bradley (M. D. or other)

Address BARNES HOSPITAL Date signed

(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 Paul A. Keith

Licensed Embalmer No. 3612

P. O. Address 2317 Lafayet

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

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