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13-40
7-39
X2959

NOV 16 1940
Registration District No. 791

Primary Registration District No.

Registrar's No. 8390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: 2630 Palm St. 2
(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)

3. (a) PRINT FULL NAME Anthony Bielicki

3. (b) If veteran, name war World War

3. (c) Social Security No.

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

6. (b) Name of husband or wife Helena 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased March 3 1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 7 Days 4 If less than one day hr. min.

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

10. Usual occupation Chauffeur 7

11. Industry or business Post Office 7

12. Name Jozef Bielicki

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

14. Maiden name Mary Borrowski

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

16. (a) Informant Helen Bielicki
(b) Address 2630 Palm

17. (a) Burial (b) Date thereof 10/10/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

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

19. (a) OCT 9 1940 (b) J. E. ...
(Date received local registrar) (Registrar's signature)

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. 2630 Palm
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7th
year 1940 hour 2:50 minute A. M.

21. I hereby certify that I attended the deceased from
....., 19....., to 19.....;
that I last saw h..... alive on 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion;
Contrib: Chronic Parenchymatous
Nephritis;

Due to

Due to

Other conditions MI
(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? Yes (e) Means of Injury MI

23. Signature W. E. ... (M. D. or other) 3
Address Exp. ... Date signed 10/8/40

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.....

Gay W. Wilkinson

Licensed Embalmer No. 3575

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, fact should be so stated above.