

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 8918

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
(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: City Infirmary  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 42 yrs. 10 mo. 24 da  
In this community 17 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 13  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5800 Arsenal  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? 57 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24  
year 1940 hour 9:00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Sept. 24, 1940, to Oct. 24, 1940;  
that I last saw him alive on Oct. 24, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Head of Paralysis Duration \_\_\_\_\_

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

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

Other conditions arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy same

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 10-31-40  
(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 Geo. J. Gyzalik, M.D. (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Achille Decker

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 Single

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

7. Birth date of deceased Nov. 24 1856  
(Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation None

11. Industry or business 7

12. Name Joseph Decker

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

14. Maiden name Catherine Stronlea

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

16. (a) Informant's own signature J. J. Sullivan

(b) Address 5800 Arsenal

17. (a) BURIAL (b) Date thereof 10-31-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Sullivan & Kelly

(b) Address 1416 N. Taylor Ave.

19. Oct 30 1940 (b) J. J. Sullivan (Registrar's signature)

(Date received local registrar)

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.

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.....

*myself*....., Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

*city license #7281* Signed *Raymond E. Gehrke*  
Licensed Embalmer No. *3985*

P. O. Address *St. Louis, Mo*

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

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