

No. 2
4-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37264**
9537
Registrar's No.

Registration District No. **791**

Primary Registration District No. **1003**

FILED DEC 11 1940

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:
Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day.**
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County.....
(c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
(d) Street No. **3234 Itaska St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **55** years.

3. (a) PRINT FULL NAME **Frank Sikorski**
3. (b) If veteran, name war **----**
3. (c) Social Security No. **----**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **19th**
year **1940** hour **2** minute **50** A. M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Pelagia**
6. (c) Age of husband or wife if alive **12** years
7. Birth date of deceased **February 1865**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 17** 19**40** to **Nov 18** 19**40**
that I last saw him alive on **11-18-40**
and that death occurred on the date and hour stated above.

8. AGE: Years **75** Months **9** Days **7**
If less than one day
.....hr.min.

Immediate cause of death
Cholelithiasis
Due to **Cholelithiasis**
Duration
?

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

Due to **Cholelithiasis**
Other conditions
(Include pregnancy within 3 months of death)

10. Usual occupation **Broommaker**
11. Industry or business **Retired 18 yrs.**

Major findings:
Of operations **1/21**
Of autopsy.....

MOTHER FATHER
12. Name **Joseph Sikorski**
13. Birthplace **Poland**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Roganska**
15. Birthplace **Poland**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Frank Sikorski**
(b) Address **3234 Itaska St.**

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?

17. (a) **Burial** (b) Date thereof **Nov. 22, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **SS. Peter & Paul Cem.**

18. (a) Signature of funeral director **J. H. Gebken & Co.**
(b) Address **2842 Meramec St.**

While at work? (Specify type of place) (e) Means of injury.....
23. Signature **William J. Hans** (M. D. or other)
Address **4535 Virginia** Date signed **11/20/40**

19. (a) **NOV 20 1940** (b) **J. F. Bredbeck**
(Date received local registrar) (Signature)

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.....

Joseph S. Benz

....., Registered Apprentice No. 218

working under my personal supervision.

Signed.....

Herman A. Gebken

Licensed Embalmer No. 2120

P. O. Address 2842 Meramec St.
St. Louis, Mo.

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.