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S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40212

Registration District No. 1791 — Primary Registration District No. 1003 — Registrar's No. 9983

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

1. PLACE OF DEATH:
(a) County 1
(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 Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 Days (Specify whether years, months or days)
In this community 27 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St Louis 26 (If outside city or town limits, write "RURAL")
(d) Street No. 1110 Angelrodt St (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME MARGARET-ANN-MAZURSKIEW33
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife BENT-CATH-MAZURSKIEW33
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Nov (Month) 4th (Day) 1940 (Year)

8. AGE: Years | Months | Days 27 | If less than one day 7 hr. ..... min.

9. Birthplace City Hosp (City, town, or county) St Louis Mo (State or foreign country)
10. Usual occupation 0
11. Industry or business 0
FATHER
12. Name BEN MAZURSKIEW33 0
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Catherine Hense
15. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
16. (a) Informant Catherine Mazurskiew
(b) Address 1110 A Angelrodt ST
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/40 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Calvary Cemetery
18. (a) Signature of funeral director Watson Bockage
(b) Address 6536 Clayton Rd Rich Hts Mo
19. (a) (Date received [illegible]) (b) J. F. Brecheck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 30, year 1940 hour 8:00 minute A. M.
21. I hereby certify that I attended the deceased from November 4, 1940 to November 30, 1940; that I last saw her alive on November 30, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Impetigo — Duration 18 days
Due to 13 C
Due to
Other conditions Dysentery - Idiopathic type unknown (Include pregnancy within 3 months of death)
Major findings: Of operations Broncho-pneumonia
Of autopsy As above

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 1
23. Signature J. H. Wallace (M. D. ~~or other~~)
Address 1515 Lafayette Ave., Date signed 12/4/40

(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 J. G. Sullivan

Licensed Embalmer No. 1123

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.