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4-41
7-39
X26390

FILED AIC '0 1941
Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **4904 Davison**

(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:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community **50 years** / (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mateusz Dawid (DAWID)**

3. (b) If veteran, name war **No**

3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Veronica**

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

7. Birth date of deceased **September 18, 1866**
(Month) (Day) (Year)

8. AGE: Years **74** Months **9** Days **12** If less than one day hr. min.

9. Birthplace **Poland 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business

MOTHER FATHER { 12. Name **unknown**

13. Birthplace **Poland 4**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

15. Birthplace **Poland 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Andrzejewski (daughter)**

(b) Address **4904 Davison**

17. (a) **Burial** (b) Date thereof **7/2/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **St. Louis Funeral Home**

(b) Address **2205 St. Louis, Avenue**

19. (a) **JUL 1 1941** (b) **T. J. Bredich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County

(c) City or town **Saint Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **4904 Davison**
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) **No**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **29**
year **1941** hour **9** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Jan 10** 19**39** to **JUNE 29** 19**41**
that I last saw him alive on **June 29** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocarditis** Duration **7 da**

Due to **Acute & Chronic Intestinal Nephritis** **2 yrs.**

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)

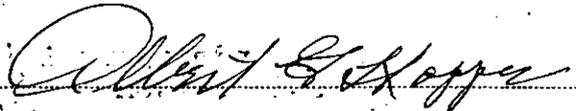
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature **Francis Conway M.D.** (M. D. or other) **Med**
Address **5021 Union Blf** Date signed

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.....



Licensed Embalmer No. 2971

P. O. Address.....

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, fact should be so stated above.