

No. 2  
-1-4-41  
5-17-39  
I X26390

DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **30039**  
Registrar's No. **7378**

Registration District No. **791** Primary Registration District No. **1008**

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town **St. Louis**  
(c) Name of hospital or institution:  
**4630 Bessie Ave.**  
(d) Length of stay: In hospital or institution.....  
In this community.....

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County.....  
(c) City or town **St. Louis**  
(d) Street No. **4630 Bessie Ave.**  
(e) Citizen of foreign country?.....

3. (a) PRINT FULL NAME **Mary Rafalowski**  
(b) If veteran, name war..... (c) Social Security No. **No**

20. DATE OF DEATH: Month **Sept** day **11** year: **1941** hour **7** minute **30** A.M.

4. Sex **Female** 5. Color or race **White**  
6. (b) Name of husband or wife **Stanley Rafalowski**  
7. Birth date of deceased **December 10 1896**

21. I hereby certify that I attended the deceased from.....  
that I last saw h..... alive on.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

8. AGE: Years **44** Months **9** Days **1**  
If less than one day.....

Due to **Fatty infiltration of myocardium**  
Due to **Oedema of lungs**

9. Birthplace **St. Louis Missouri**  
10. Usual occupation **Housewife**

Other conditions.....  
Major findings: Of operations.....  
Of autopsy.....

11. Industry or business.....  
12. Name **Michael Hayduk**  
13. Birthplace **Austria**  
14. Maiden name **Antoinette Czecholewski**  
15. Birthplace **Germany**

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

16. (a) Informant **Stanley Rafalowski**  
(b) Address **4630 Bessie Ave.**  
17. (a) **Burial** (b) Date thereof **9-15-41**  
(c) Place: burial or cremation **Calvary Cemetery**  
18. (a) Signature of funeral director **Stroot-Carroll**  
(b) Address **4600 Natural Bridge Ave.**  
19. (a) **SEP 12 1941** (b) **J. P. Bradeck**

23. Signature **Albert Perry** (M. D. or other) **3**  
Address **.....** Date signed **9/13/41**

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

419  
9-13

FILED  
OCT 18 1941  
791

*Dr. Albert Perry*  
MEDICAL CERTIFICATION

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

**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 Frank H. Street

Licensed Embalmer No. 2265-

P. O. Address 4600 York Bridge

**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.**