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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30248

State File No.

FILED OCT 18 1941

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

7587

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:
Enroute City Hospital 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Edward M. Mokwa
3. (b) If veteran, name war Unknown
3. (c) Social Security No. 497-10-6465

4. Sex Male ()
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Marie
6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased June 16 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 3 1 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Cab Driver

11. Industry or business Yellow Cab Co.

MOTHER FATHER { 12. Name John Mokwa
13. Birthplace Poland
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marie Mokwa
(b) Address 5349 Ashland Ave.

17. (a) Burial (b) Date thereof 9/20/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4790 Washington Ave.

19. (a) SEP 19 1941 (b) J. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")
(d) Street No. 5349 Ashland Ave. 9
(If apt., give location)
(e) (Citizen or foreign country) Physician (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17
year 1941 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h_____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____
Of autopsy Coronary Thrombosis
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 _____

23. Signature Thomas A. Callahan (M.D. or other) 33
Address Deputy Coroner Date signed 9/19/41

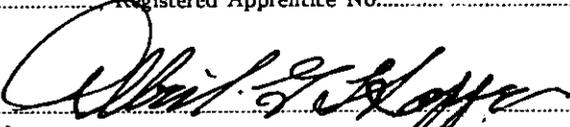
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.