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X26390

FILLED NOV 24 1941

Registration District No. **791** Primary Registration District No. **1003**

**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:  
*3204 Starks St. 1*  
 (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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... *Mo.* (b) County..... *000*  
 (c) City or town..... *St. Louis* *19*  
 (If outside city or town limits, write "RURAL") *9, 15*  
 (d) Street No. *3204 Starks*  
 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

**3. (a) PRINT FULL NAME** *Joseph S. Kalinowski*  
**3. (b) If veteran,** name war..... *Worlds War*  
**3. (c) Social Security** No. *488-09-5515*

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month *Oct* day *23*  
 year *1941* hour *7<sup>00</sup>* minute *P.M.*  
**21. I hereby certify that I attended the deceased from** *Oct 1* 19*41* to *Oct 23* 19*41*  
 that I last saw him alive on *Oct 22* 19*41*  
 and that death occurred on the date and hour stated above.

**4. Sex** *Male* **5. Color or race** *White*  
**6. (a) Single, widowed, married, divorced** *married*  
**6. (b) Name of husband or wife** *Frances Kalinowski*  
**6. (c) Age of husband or wife if alive** *42* years  
**7. Birth date of deceased** *July 19, 1891*  
 (Month) (Day) (Year)  
**8. AGE:** Years *50* Months *3* Days *4*  
 If less than one day: hr. min.

Immediate cause of death.....  
*Acute Myocarditis*  
*Chronic condition of Myocarditis*  
*Bronchial Asthma*  
 Due to.....  
 Due to.....

**9. Birthplace** *St. Louis Mo. 0*  
 (City, town, or county) (State or foreign country)  
**10. Usual occupation** *Shoe worker*

Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations..... *93d*  
 Of autopsy..... *none*  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**11. Industry or business**  
**12. Name** *Ladislaus Kalinowski*  
**13. Birthplace** *Poland*  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** *Anna Haas*  
**15. Birthplace** *Poland*  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** *Frances Kalinowski*  
**(b) Address** *3204 Starks*  
**17. (a) Burial, cremation, or removal** *burial*  
**(b) Date thereof** *Oct 27 1941*  
 (Month) (Day) (Year)  
**(c) Place: burial or cremation** *New S. S. Peter & Paul*

**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

**18. (a) Signature of funeral director** *J. J. Dinkiewicz*  
**(b) Address** *5401 S. Grand Blvd*  
**19. (a) OCT 25 1941** (Date received local registrar)  
**(b) J. F. Brudeck** (Registrar's signature)

**23. Signature** *H. J. Shelton M.D.* (M. D. or other)  
**Address** *4703 Virginia* **Date signed** *10-24-41*

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

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**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.....

*Walter G. Burnley*

Licensed Embalmer No..... *42020*

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.**