

DEC 23 1941

Registration District No. 784

Primary Registration District No. 202

Registrar's No. 2556

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm. Nov. 4, 1941
(Specify whether
In this community unknown.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 109
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9
(d) Street No. 615 Walnut Street (If rural, give location) 1
(e) Citizen of foreign country? (Naturalized) (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14th
year 1941 hour 5 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from
November 4, 1941 to December 14, 1941
that I last saw him alive on December 14, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Abscess, pulmonary, right
lower lobe, non-tuberculous Unknown

Due to _____

Due to _____

Other conditions None.
(Include pregnancy within 3 months of death)

Major findings: Thoracentesis, right chest,
Of operations November 12, 1941.
Of autopsy No 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) no
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, or farm, in industrial place, in public place?
While at work? _____ (Specify type of place) _____ (Specify type of injury)

23. Signature L. M. COCHRAN, M.D., (M. D. or other) _____
Address Chief Medical Officer, Date signed 12/15/41

3. (a) PRINT FULL NAME Frank W. Glotkowski

3. (b) If veteran, name war World War 3. (c) Social Security No. Unavailable

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased June 18, 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 5 26 _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business WPA

12. Name Anton Glotkowski

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

14. Maiden name Mary (surname unknown)

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

16. (a) Informant M. Schellig

(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) Burial (b) Date thereof Dec. 17, 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 7814 S. Broadway

19. (a) DEC 16 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.