

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 81

1. PLACE OF DEATH

(a) County Person

(b) City or town Rural, Washington

(c) Name of hospital or institution: State Hosp #32
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 yrs 9 months
(Specify whether years, months or days)

In this community Same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis City

(c) City or town St. Louis City
(If outside city or town limits, write "RURAL")

(d) Street No. Dr
(If rural, give location)

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

3. (a) PRINT FULL NAME Thomas Malatinski

3. (b) If veteran, name war

3. (c) Social Security No. None

4. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21
year 1942 hour 1 minute A.M.

21. I hereby certify that I attended the deceased from Nov 15
1938 to Aug 21 1942
that I last saw him alive on Aug 20 1942
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 Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 17 years

7. Birth date of deceased: Sept. 17 1889
(Month) (Day) (Year)

Immediate cause of death: Bilateral Pulmonary Tbc.
Demolition Process

Due to

Due to

Other conditions: 1361
(Include pregnancy within 3 months of death)

8. AGE: Years 52 Months 11 Days 4
If less than one day hr. min.

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

10. Usual occupation: Dr

11. Industry or business

12. Name Dr

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

14. Maiden name Dr

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

Major findings: 1361
Of operations

Of autopsy: Bilateral pulmonary tubercular

16. (a) Informant: Hosp. Recd.

(b) Address: Nevada, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 24 - 1942
(Month) (Day) (Year)

(c) Place: burial or cremation: State Hospital Emergency

18. (a) Signature of funeral director: Ferry Funeral Home

(b) Address: Nevada, Mo.

19. (a) Aug 23, 1942 (Date received local registrar) (b) Elizabeth Breckenridge (Registrar's signature)

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?

While at work? (Specify type of place) (a) Means of injury

23. Signature: Wm O. Casner (M. D. or other)
Address: Nevada Date signed: 8/21/42

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

108
0
0

108
0
0

MOTHER FATHER

RECEIVED

District Health Officer No. 7.

District File Number..... 9-42-971

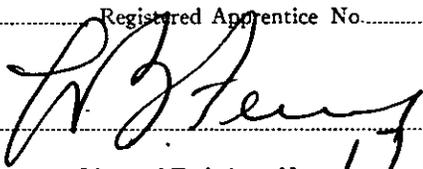
Date Filed..... 9-9-42

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. 1760.....

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.