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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35423
State File No. 9324
Registrar's No.

FILED NOV 23 1942

Registration District No. 218

Primary Registration District No. 1003

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

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: Faith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 4 days years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 109
(d) Street No. 4483 Lee Ave (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BOLESLAW GRONSKI
3. (b) If veteran, name war _____ 3. (c) Social Security No. 494-108490

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 12 year 1942 hour 4 minute _____ P. M.
21. I hereby certify that I attended the deceased from November 9 1942 to Nov. 12 1942 that I last saw him alive on Nov. 12 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 Adelle 6. (c) Age of husband or wife if alive 56 years (Day) (Year)
7. Birth date of deceased 12 (Month) 26 (Day) 1885 (Year)

Immediate cause of death Tobacco poisoning Duration _____
via

8. AGE: Years Months Days If less than one day
56 10 16 hr. _____ min.

Due to _____
Due to _____
Other conditions Agramulocytosis (Include pregnancy within months of death)
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Poland (City, town, or county) (State or foreign country)
10. Usual occupation Millender
11. Industry or business Semi-Steel
12. Name Ludwig Gronski
13. Birthplace Poland (City, town, or county) (State or foreign country)
14. Maiden name Adelle Kowmacks
15. Birthplace Poland (City, town, or county) (State or foreign country)

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

MOTHER FATHER
16. (a) Informant Mrs. Rose Gronski (Sister-in-law)
(b) Address 3017 Waine
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-42 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director St. Louis Funeral Home
(b) Address 2105 St. Louis Ave
19. (a) NOV 15 1942 (Date received by local registrar) (b) J. F. Bredeck (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? _____
(Specify type of place) (e) Means of injury _____
23. Signature Ernest Powell (M. D. or other) M.D.
Address 4155 N. Newstead Date signed 11-14-42

G06262

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:

Albert W. Nagge

Licensed Embalmer No. *1861*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 9524

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7th South Hospital
(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 Baleslaw Gronski
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color & race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Florence Gronski 6. (c) Age of husband or wife if alive 36 years 26 (Day) 1892 (Year)
7. Birth date of deceased: 1 2 (Month) 26 (Day) 1892 (Year)

8. AGE: Years 56 Months 10 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) FEB 16 1943 (b) J. F. Bredeck
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12
year 1942 hour _____ minute _____ 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 _____ Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of 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) _____

(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) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

35423