

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 ED SEP 17 1943
 Registration District No. 318

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
 Primary Registration District No. 1003

30193
 State File No.
 Registrar's No. 7923

1. PLACE OF DEATH:

(a) County St. Louis Mo
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4718 St. Louis Ave
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
 In this community 55 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

SIMON MARKIEWICZ

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife.

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

7. Birth date of deceased JUNE 20 1860
 (Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days 16 If less than one day hr. min.

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

10. Usual occupation RETIRED

11. Industry or business.

12. Name UNKNOWN

13. Birthplace UNKNOWN
 (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. Agnes (daughter)

(b) Address 4718 St. Louis Ave

17. (a) Burial (b) Date thereof 9/8/43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director St. Louis Funeral Home

(b) Address 2205 St. Louis Ave

19. (a) SEP 7 1943 (b) St. Louis
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4718 St. Louis Ave
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5
 year 1943 hour minute 30 M.

21. I hereby certify that I attended the deceased from April 2 1943 to Sept 5 1943
 that I last saw him alive on Sept 4
 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis Duration 9 days

Due to Chronic Nephritis

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?

23. Signature John J. Kehoe (Specify type of place) (e) Means of injury
 Address 4445 St. Louis Date signed 9/4/43

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.....

Henry M. Brammer

Licensed Embalmer No. *4200*

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.