

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:  
St. Johns Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 Days.  
(Specify whether  
In this community About. 55 Years.  
years, months or days)

3. (a) PRINT FULL NAME Matthew Bukowski.

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 8 10 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 4 5 hr. min.

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John. Bukowski  
13. Birthplace Poland 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Poland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Julius. Bukowski.  
(b) Address 4932 Mardell

17. (a) Burial (b) Date thereof 12-18-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Booth & Booth  
(b) Address 2228 St. Louis, Ave

19. (a) DEC 17 1943 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4066 Maffith. Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 15  
year 1943 hour 9 minute 55 a.m.

21. I hereby certify that I attended the deceased from December 7, 1943 to December 15, 1943  
that I last saw him live on December 15, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia 4 days

Due to Chronic hepatitis +  
general arteriosclerosis

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 151

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 Arthur Sussner (M. D. or other) M.D.  
Address 2202 University St. Date signed 12/17/43

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 *Marie A. Cashion*  
Licensed Embalmer No. *3949*  
P. O. Address *St. Louis Mo*

**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.**