

No. 2
-5-42
-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8947
2902
Registrar's No.

FILED APR 1 1944
Registration District No. 1818

Primary Registration District No. 1003

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: Missouri Baptist 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....
(c) City or town..... St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No..... 403 St. George Str
(If rural, give location)
(e) Citizen of foreign country?..... No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Mar. day..... 27
year..... 1944 hour..... 5 min..... 50 A. M.

21. I hereby certify that I attended the deceased from.....
16....., 1944, to..... March 27.....
that I last saw her alive on..... March 26....., 1944
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Trauma corae Meningitis Duration.....
30 Days

Due to.....
13 1/2
Due to.....
Acute Bright Disease Days.....
Days

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..... W. Salisbury (M. D.)
Address..... 3058 Lafayette Date signed..... 3/27-44

3. (a) PRINT FULL NAME..... ANNA GALAYDA
3. (b) If veteran, name war..... No
3. (c) Social Security No.....

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

6. (b) Name of husband or wife..... Wasył
6. (c) Age of husband or wife if alive..... 43 years

7. Birth date of deceased..... Jan. 29 (Month) (Day) (Year)
1902

8. AGE: Years..... 42 Months..... 2 Days..... 28
If less than one day..... hr..... min.....

9. Birthplace..... Des Logge Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation..... House Wife

11. Industry or business..... House Work

MOTHER FATHER

12. Name..... Affis Fedak.

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

14. Maiden name..... Rose Kimkorsky

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

16. (a) Informant..... Wasył Galayda

(b) Address..... 403 St. George St.

17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof..... 3/30/44
(Month) (Day) (Year)

(c) Place: burial or cremation..... Mt. Hope Cemetery.

18. (a) Signature of funeral director..... Wm. C. Murrell

(b) Address..... 1926 Allen Av.

19. (a) MAR 28 1944 (Date received local registrar)
J. F. Brudeck (Registrar's signature)

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

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 me
.....; Registered Apprentice No.
working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen av

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.