

FILED MAR 27 1944 318

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County St. Louis,
(b) City or town St. Louis,
(c) Name of hospital or institution:
4040a Sullivan Ave.
(If not in hospital) or institution, write street number or location
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

3. (a) PRINT FULL NAME Michalina Sulkowski
3. (b) If veteran, name war -
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 John F. Sulkowski
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased October 28 (Month) (Day) (Year) 1883

8. AGE: Years Months Days If less than one day
60 4 17 4 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Joseph Wisniewski

12. Name Joseph Wisniewski

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

14. Maiden name Theorita Pizner

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

16. (a) Informant Angela M Sulkowski

(b) Address 4040a Sullivan Ave

17. (a) Burial (b) Date thereof March 18th 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. F. Budick
(b) Address 2233 University St.

19. (a) Date received local registrar MAR 17 1944
(b) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:
Missouri
(a) State Missouri (b) County St. Louis,
(c) City or town St. Louis,
(d) Street No. 4040a Sullivan Ave
(If outside city or town limits, write "RURAL")
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION
20. DATE OF DEATH: March 15th. 1944
Month 7 day 20 A. M.
year hour minute

I hereby certify that I attended the deceased from January 23, 1944 to March 15th, 1944
that I last saw him alive on March 14, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 hr
Due to Hypertension 6 mos.
Cardio-renal disease 6 mos.

Due to 12/1

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 12/1
Of autopsy

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 Arthur Swelson (M. D. or other) M.D.
Address 7202 University Date signed 3/11/44
While at work? (Specify type of place) (e) Means of injury

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

MOTHER FATHER

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

Edward J. Bockhorn

Licensed Embalmer No. *2502*

P. O. Address *Clayton 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.