

12124

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 8 3 1944
Registration District No. 314A7

Primary Registration District No. 3069

Registrar's No. 787

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town RICHMOND HEIGHTS
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution NEW ST. MARY'S HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 WEEKS
(Specify whether)
 In this community LIFE
years, months or days

3. (a) PRINT FULL NAME JERRY C. MAJEWSKI
 8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased NOV. 16TH 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

10. Usual occupation INFANT

11. Industry or business _____
 { 12. Name JOHN MAJEWSKI.
 13. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)
 14. Maiden name EVERETT B. PAULS.
 15. Birthplace HARNESVILLE MO
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Majewski

(b) Address 4611 McPherson Ave

17. (a) BURIAL (b) Date thereof APR. 7 - 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM, Brookland, Ind Co

18. (a) Signature of funeral director _____ (b) Address 1827 Hogan STR.

19. (a) APR 1 - 1944 (b) E. J. ...
(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. 4611 McPHERSON AVE
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month MCH. day 31ST
 year 1944 hour 8:50 minute AM

21. I hereby certify that I attended the deceased from Feb 8,
 _____, 1944, to March 31, 1944
 that I last saw him alive on March 30, 1944
 and that death occurred on the date and hour stated above

Immediate cause of death Pneumo-pneumonia Duration 50 days

Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy 107

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 Julius A. Rosen (M. D. or other) M. D.
 Address 4122 Washington Date signed 3-31-44

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

Rev. 5-17-39
1 X1951

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 No Embalming
March 31st / 1914
John J. Brockland
Licensed Embalmer
P. O. Address Brockland Ind. C.

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, above space should be left blank.

APR 1 1914