

FILED MAY 15 1944

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community 38
years, months or days)

3. (a) PRINT FULL NAME Stella Kaliszewski

3. (b) If veteran, _____ **3. (c) Social Security**
name war _____ No. _____

4. Sex Female **5. Color or race** White **6. (a) Single, widowed, married,** Divorced Married
6. (b) Name of husband or wife. Ambrose Kaliszewski **6. (c) Age of husband or wife if** alive 49 years
7. Birth date of deceased. May 9 1902
(Month) (Day) (Year)

8. AGE: Years 41 Months 11 Days 19 If less than one day
hr. _____ min. _____

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

10. Usual occupation. Housewife

11. Industry or business. _____

12. Name. John Michalicki
13. Birthplace. Poland 4
(City, town, or county) (State or foreign country)
14. Maiden name. Leopoldina Gorecka
15. Birthplace. Poland 4
(City, town, or county) (State or foreign country)

16. (a) Informant. Ambrose Kaliszewski

(b) Address. 1829 N. 25 St.

17. (a) _____ **(b) Date thereof.** 45 2 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Old St Peter - Paul

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

(b) Address. 2205 St. Louis Ave

19. (a) MAY 1 **(b)** 1944 **(c)** J. Branch
(Date received local registrar) (Registrar's signature)

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. 1829 N. 25 St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28th
year 1944 hour 3:50 minute _____ P. M.

21. I hereby certify that I attended the deceased from April 26th
_____, 1944, to April 28th, 1944
that I last saw h. or alive on April 28th, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrosis of lungs Duration _____

Due to _____

Due to _____

Other conditions.
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy refused

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. George W. Salmon, M.D. (M. D. or other)
Address 1515 Lafayette Date signed 4/28/44

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

John Agorowski

Licensed Embalmer No. *3398*

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.