V. S. No. 2
00M—8-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

20917

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 14 1944 1818

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1003

State File No. 23364

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 6778

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 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 mos. (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Mo. (b) County 17

(c) City or town St Louis 9 (If outside city or town limits, write "RURAL")

(d) Street No. 1943 N. 9 th Str 26 (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mary Ratka

3. (b) If veteran, name war .....

3. (c) Social Security No. -- ---

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced widowe 2

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Nov 1 (Month) (Day) 1894 (Year)

8. AGE: Years ~~50~~ 49 Months 8 Days 30 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name S Ostrowaski
13. Birthplace Poland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Poland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Chester Ratka

(b) Address 1943 N 9th str

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-44 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Central Und. Co

(b) Address 1841 Cass Ave

19. (a) AUG 3 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st year 1944 hour 7 minute 30 P M.

21. I hereby certify that I attended the deceased from 12/9/43 ....., 19 ~~44~~ to July 31st, 19 44 that I last saw her alive on July 31st, 19 44 and that death occurred on the date and hour stated above.

Immediate cause of death Cord tumor

Due to 57

Due to .....

Other conditions Cord bladder and (Include pregnancy within 3 months of death) diabetes ulcers.

Major findings:
Of operations Cord tumor unqualified
Of autopsy none obtained

Duration

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature [signature] (Mind or other)

Address 1515 Lafayette Date signed 8/2/44

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....3575

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.