

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 14 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6817

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

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... 20 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo (b) County..... 000
125

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

(d) Street No. 5733 WATERMAN
(If rural, give location)

(e) Citizen of foreign country?..... 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME MIKE WYNOKOFSKY

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30th
year 1944 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 10th
....., 1944, to July 30th, 1944
that I last saw him alive on July 30th, 1944
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color of hair 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: Sept 17 1900
(Month) (Day) (Year)

Immediate cause of death..... Cerebral
leury.

Due to.....

Due to.....

Other conditions (Include pregnancy, within 3 months of death)..... H7

8. AGE: Years 43 Months 10 Days 13 If less than one day hr. min.

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

10. Usual occupation JANITOR

Major findings: Of operations.....

Of autopsy..... same

PHYSICIAN.....

Underline the cause to which death should be charged statistically.

MOTHER { 11. Industry or business.....

FATHER { 12. Name ARRON WYNOKOFSKY

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

14. Maiden name..... W. P.

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

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..... Tracy Feinberg (M. D. or other) 7/31/44
Address..... 1517 Lafayette Date signed.....

16. (a) Informant St. Louis City Hospital

(b) Address 2320 Market Street

17. (a) BURIAL (b) Date thereof Aug 5 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director..... J. F. Brudwick

(b) Address 425 E. Grand

19. (a) AUG 4 1944 (b) (Registrar's signature).....
(Date received local registrar) (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 James A. Lamm
Licensed Embalmer No. 4142
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.