S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1944

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 29689

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8384

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
DePaul Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
In this community 9 Hrs.
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Ann

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2202 N. Market St 9
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Infant Ostrowski

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex 0 Male

5. Color or race White

6. (a) Single, widowed, married, divorced 0 Single

6. (b) Name of husband or wife Nil

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

7. Birth date of deceased 10/1/44 (Month) (Day) (Year)

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

9. Birthplace St. Louis (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Nil

11. Industry or business Nil

FATHER
12. Name Stanley Ostrowski
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Pauline Zitzman
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Stanley Ostrowski
(b) Address 2202 N. Market St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemt

18. (a) Signature of funeral director Harrigan & Sharpe Und Co
(b) Address 4415 Washington Blvd.

19. (a) OCT 2 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 1st
year 1944 hour 12:30 P.M. minute M.

21. I hereby certify that I attended the deceased from 3 A.M. - 10-1- 1944 to 12:30 p.m. 10/1 1944;
that I last saw him alive on 10-1- 1944
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death atelectasis | 9 hrs |
| Due to | |
| Due to 161 | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

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

Signature Arthur Swalock (M. D. or other) M.D.

Address 2202 University Date signed 10/2/44

(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:

No Embalmig, Registered Apprentice No.

working under my personal supervision.

Albert G Hoppe

Sig Albert G Hoppe

Licensed Embalmer No. 2974

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.**