

FILED NOV. 1944

Registration District No. _____ Primary Registration District No. **1003**

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

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:
3302 Commonwealth
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Von Choinski, Edward W.
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Wid**
6. (b) Name of husband or wife **Elisabeth Von Choinski**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **October 28, 1864**
(Month) (Day) (Year)

8. AGE: Years **79** Months **11** Days **24**
If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **retired**

11. Industry or business _____

MOTHER FATHER

12. Name **Timothy Choinski**
13. Birthplace **Warsaw Poland**
(City, town, or county) (State or foreign country)
14. Maiden name **Not Known**
15. Birthplace **Poland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs W. Scott**
(b) Address **3302 Commonwealth**

17. (a) **Burial** (b) Date thereof **Oct. 25, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New Ss. Peter & Paul**

18. (a) Signature of funeral director **Michael J. Croghan**
(b) Address **7146 Manchester**

19. (a) **OCT 24 1944** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis Mapleswood**
(c) City or town **Mapleswood ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **3302 Commonwealth**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **22**
year **1944** hour **3:15** minute **15 P.** M.
21. I hereby certify that I attended the deceased from
Nov 25 to **Oct 22** 19 **44**
that I last saw him alive on **10. 22** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Due to _____
Due to _____
Other conditions **None**
(Include pregnancy within 3 months of death)

Duration

Major findings: **None**
Of operations _____
Of autopsy **None**

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) (c) Means of injury _____
23. Signature **Therese Schuck** (M. D. or other)
Address **1703 1/2 Grand** Date signed **10/25/44**

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 Agonowski

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.