

S. No. 2
FORM-5-43
Rev. 5-17-39
X 36671

FILED DEC 27 1944

Registration District No. _____ Primary Registration District No. **1000**

1. PLACE OF DEATH: *St Louis*

(a) County *St Louis*

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

(c) Name of hospital or institution: *City Hospital*
(If not in hospital or institution, write street number or location) *0*

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community *39 years*
years, months or days *St Louis*

2. USUAL RESIDENCE OF DECEASED:

(a) State *St Louis MO* (b) County *St Louis*

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

(d) Street No. *4954 Thekla*
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME: *(Steve) Tabaka*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex <i>male</i>	5. Color or race <i>w</i>	6. (a) Single, widowed, married, divorced <i>married</i>
6. (b) Name of husband or wife <i>Maryann</i>	6. (c) Age of husband or wife if alive <i>59</i> years	
7. Birth date of deceased <i>May 6 1875</i> (Month) (Day) (Year)		

8. AGE:	Years	Months	Days	If less than one day
	<i>68</i>	<i>7</i>	<i>5</i>	hr. min.

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

10. Usual occupation *Labor*

11. Industry or business _____

12. Name *Kasper Tabaka*

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

14. Maiden name *Maryann Sadlowska*

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

16. (a) Informant *Maryann Tabaka*

(b) Address *4954 Thekla St*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *12 15 44*
(Month) (Day) (Year)

(c) Place: burial or cremation *Calvary Cemetery*

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

(b) Address *2205 St Louis ave*

19. (a) *DEC 13 1944* (Date received local registrar) *J. F. Bredeck* (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *11*
year *1944* hour *10* minute *30 P* M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death: *Internal Hemorrhage from ruptured Aorta*

Due to *non-traumatic*

Due to _____

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature *Patrick E Doyle* (M.D. or other) *Dr*

Address *124 W* Date signed *12/12/44*

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

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 Ogonoski
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.