

FILED JAN 5 1945  
Registration District No. **318**

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:  
De Paul Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Josephine Paczkowski-Wadas

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Anton Wadas 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 3, 1868  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>9</u>	<u>24</u>	hr. _____ min.

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Don't Know

13. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know

15. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Johnson

(b) Address 4430 Alaska Ave.

17. (a) Burial (b) Date thereof Dec. 30, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old SS. Peter and Paul

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 1/2 Grand Bl.

19. (a) DEC 29 1944 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mad  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 1110 Chambers St. (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27  
year 1944 hour 2 minute 0 P. A. M.

21. I hereby certify that I attended the deceased from 10-27-44 19, to 12-27-44 19;  
that I last saw him aw alive on 12-27-44 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death DIABETES - MELLITUS  
Due to DIABETIC - GANGRENE  
Due to CHRONIC ENDOCARDITIS

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 J. J. Hainrich (M. D. or other) \_\_\_\_\_  
Address 1901 Madison Date signed 12-29

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

*Embalmer's Separate Cert. to be filed*

**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. 3722

P. O. Address 412 Duchouquette St.

**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.**