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FILED JAN 31 1945 18

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

849
State File No. _____
Registrar's No. 776

Registration District No. _____

Primary Registration District No. _____

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. Anthony 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) 2 weeks 2 days

3. (a) PRINT FULL NAME FRANCES-TRETKOWSKI

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Dec 26 1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name Julian Rutkowski

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

14. Maiden name Justyna Babstra

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

16. (a) Informant Robert Tretkowski

(b) Address 4452 So Compton Ave

17. (a) Burial (b) Date thereof Jan 27 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Helen Ambrowski

(b) Address 5401 So Grand Blvd

19. (a) JAN 25 1945 J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town St. Louis Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 4452 So Compton Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23
year 1945 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from January 5, 1945, to January 23, 1945
that I last saw her alive on January 23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism

Due to PT. was operated on 1-19-45 for intestinal obstruction

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Abdominal Adhesions
Of operations: Cause obstruction
Of autopsy: Pulmonary Embolism

Duration
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)
(e) Means of injury _____

23. Signature H. J. Shelton (M. D. or other) O.M.D.
Address 4763 Virginia Date signed 1-24-45

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..... *Albert W. Karp*

Licensed Embalmer No..... *1861*

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.

Registration District No. 318

Primary Registration District No. 1003

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: _____
(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 Frances Trethowski

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased See 26
(Month) (Day) (Year)

8. AGE: Years 68 Months 0 Days 28 if less than one day, min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) FEB 7 1945 (b) J. F. Bredeck
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1945 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

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)

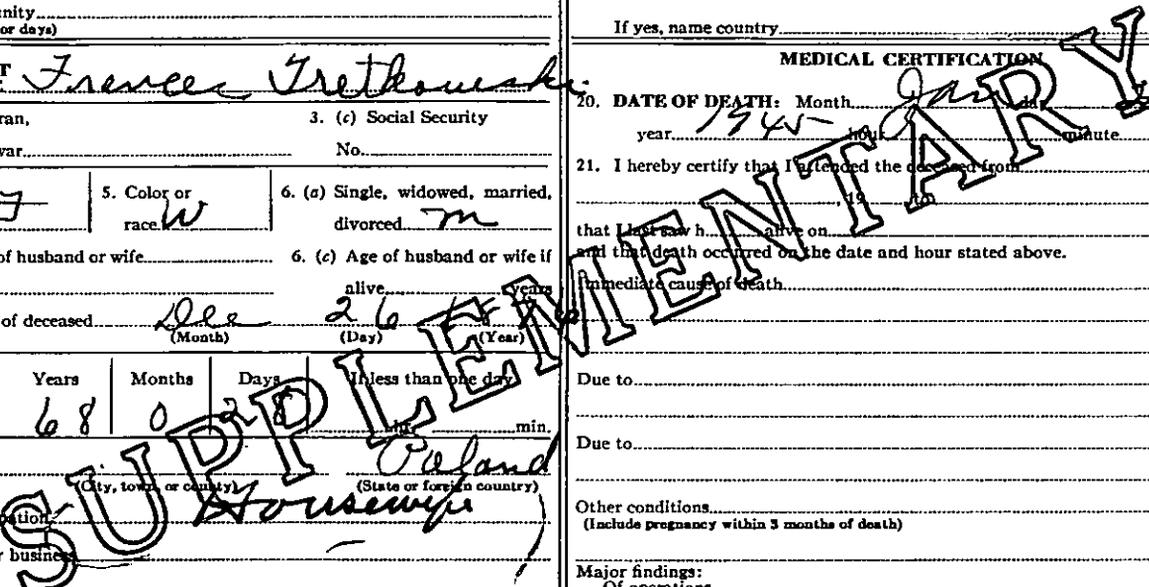
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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



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