

No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4146
Registrar's No. 1013

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: Alexian Bros. 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 Michael Dobrovolsky Sr.
3. (b) If veteran, name war No 3. (c) Social Security No. _____
4. Sex Male 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 _____ years
7. Birth date of deceased Unknown abt. 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt. 77 Unknown hr. min.

9. Birthplace Poland
(City, town, or county) (State or foreign country)
10. Usual occupation Laborer

11. Industry or business _____
12. Name Peter Dobrovolsky
13. Birthplace Poland
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Michael Dobrovolsky Jr.
(b) Address 2624 De Kalb Str.
17. (a) Burial (b) Date thereof 2/3/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery
18. (a) Signature of funeral director Wm. C. Myrdell
(b) Address 1926 Allen Ave.
19. (a) FEB 1 1945 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 2624 DeKalb Str.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 30,
year 1945 hour 7.00 minute _____ P. M.
21. I hereby certify that I attended the deceased from Jan 17 to Jan 30 1945
that I last saw him alive on Jan 30 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia by portals
Duration 2 days
Due to 186
Due to 18
Other conditions Fracture Femur
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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) Accident
(b) Date of occurrence Jan 17, 45
(c) Where did injury occur? This home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
See above
While at work? _____ (Specify type of place) (e) Means of injury Fall
23. Signature W. Demko (M. D. or other)
Address 8450 Grand Date signed 2/1/45

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed D. M. Davis
Licensed Embalmer No. 3741
P. O. Address 1926 allen ave

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.