

FILED MAR 9 1945

Registration District No. **318** Primary Registration District No. _____ Registrar's No. **1541**

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:
Isolation Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **12 days**
(Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME **Frank Gorski**

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

4. Sex **M.** 5. Color or race **W.** 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 **Nov. 7 1894**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
50	3	7	_____ hr. _____ min.

9. Birthplace **Missouri** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Gorski**

{ 13. Birthplace **Germany** (City, town, or county) (State or foreign country) **4**

{ 14. Maiden name **Mary** ?

{ 15. Birthplace **Germany** (City, town, or county) (State or foreign country) **4**

16. (a) Informant **Nellie Harris**

(b) Address **5600 Arsenal**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2-17-45**
(Month) (Day) (Year)

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

18. (a) Signature of funeral director **Central Und. Co.**

(b) Address **1841 Cass ave**

19. (a) **FEB 16 1945** (Date received local registrar) (b) **J. J. Bredeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County _____

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

(d) Street No. **1834 Benton**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **14** year **1945** hour **11** minute **23** a.m.

21. I hereby certify that I attended the deceased from **2-2-45**, 19____, to **2-14-45**, 19____, that I last saw him alive on **2-14-45**, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy **none**

Duration _____

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? _____

23. Signature **P. Maxwell** (M. D. or other) _____

Address **5600 Arsenal** Date signed **2-14-45**

STATEMENT BY LICENSED EMBALMER

1-10-68

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 G. Gonski
.....
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.