

U.S. No. 2
FORM-5-43
Rev. 5-17-39
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#4770
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7610**

FILED MAR 23 1945
818

1003

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2314**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis, Missouri.**

(c) Name of hospital or institution:
St. Louis City Hospital #1.

(d) Length of stay: In hospital or institution **1mo-2 days**

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____

(c) City or town **St Louis**

(d) Street No. **1438 Hogan Str.**

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

If yes, name country _____

3. (a) PRINT FULL NAME **ROSIE DREWENSKI**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** 5. Color of race **White**

6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased: **Oct 10 1871**

8. AGE: Years **73** Months **5** Days _____

If less than one day _____ hr. _____ min.

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

10. Usual occupation **N**

11. Industry or business _____

MOTHER FATHER { 12. Name **A. Kozozemski**

13. Birthplace **Poland**

14. Maiden name **unknown**

15. Birthplace _____

16. (a) Informant **Joseph Pielecki**

(b) Address **3715 Sulphar ave**

17. (a) **Burial** (b) Date thereof **3-13-45**

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

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

(b) Address **1841 Cass Ave**

19. (a) **MAR 12 1945** (Date received local registrar) **J. F. Brudak** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **10th** year **1945** hour **12:15** minute **A** M.

21. I hereby certify that I attended the deceased from **2/8/45** to **3/10/45**

that I last saw **her** alive on **3/10/45** and that death occurred on the date and hour stated above.

Immediate cause of death **Senility arteriosclerotic heart disease with decompensation**

Due to **malnutrition**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **93W**

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 **fall**

23. Signature **J. F. Brudak** (M. D. or other) **3/10/45**

Address **1515 Lafayette** Date Signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Agonoshka
.....
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.