S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 24 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18091

Registration District No. 317 — Primary Registration District No. 3069 — Registrar's No. 865

1. PLACE OF DEATH:
(a) County: St Louis
(b) City or town: R.H. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Mary's Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 hours (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: LCC
(c) City or town: St Louis (If outside city or town limits, write "RURAL")
(d) Street No.: 5626 Wabada (If rural, give location)
(e) Citizen of foreign country? ( ) (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Mary Zielinski (Green)
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: Peter
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: May (Month) 14 (Day) 1882 (Year)
8. AGE: Years 62 Months 10 Days 28 If less than one day hr. min.
9. Birthplace: St. Louis (City, town, or county) Mo (State or foreign country)
10. Usual occupation: House Wife
11. Industry or business
MOTHER FATHER
12. Name: Joseph Cherolewski
13. Birthplace: (City, town, or county) Germany (State or foreign country)
14. Maiden name: U.K.
15. Birthplace: (City, town, or county) U.K. (State or foreign country)
16. (a) Informant: Walter Green
(b) Address: 7231 Lindrose
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 10 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary
18. (a) Signature of funeral director: Calvin Kelly
(b) Address: 4386 Lindell
19. (a) APR 10 1945 (Date received local registrar) (b) E. G. McGavran MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1945 hour 5 minute 19 A.M.
21. I hereby certify that I attended the deceased from 4/6/45, 19..., to 4/7, 1945, that I last saw her alive on 4/7, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary sclerotic heart disease c̄ acute thrombosis of coronary artery	16 hrs.
Due to: Hypertension + generalized arteriosclerosis	for years
Due to:	
Other conditions: Contributing None (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): no
(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? (Specify type of place)
While at work?
(e) Means of injury: —
23. Signature: John J. Hammond (M. D. or other) M.D.
Address: 634 N. Grand Date signed 4/7/45

(Licensed Embalmer's Statement on Reverse Side)

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 James A. Lammers

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.