

S. No. 2
M-5-43
7-5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21929

State File No. _____

Registration District No. **818** Primary Registration District No. **1003** Registrar's No. **5976**

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. Louis City Hospital #1. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 67 16 days
(Specify whether years, months or days)

In this community _____
years, months or days

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. 5033 Genevieve Ave. 9
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRANK GALINSKI

3. (b) If veteran, name war No 3. (c) Social Security No. 499-01-3418

4. Sex Male 0 5. Color or race White

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

6. (b) Name of husband or wife Frances Galinski 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Oct. 20, 1882
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8th
year 1945 hour 4:45 minute A. M.

21. I hereby certify that I attended the deceased from 6/25/45
19____ to 7/8/45 19____

that I last saw h. im alive on 7/8/45 19____
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>8</u>	<u>10</u>	hr. _____ min. _____

Immediate cause of death...
Delirium Tremens

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Freight Handler
J. C. Penny & Co.

11. Industry or business _____

12. Name Joseph Galinski. 4

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

14. Maiden name Mary Berowski. 4

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

16. (a) Informant Francis Galinski

(b) Address 5033 Genevieve Ave.

17. (a) Burial (b) Date thereof July 11, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bensiek Melhaus
1431 Union Blvd.

(b) Address _____

19. (a) JUL 10 1945 (b) J. F. Budzek
(Date received local registrar) (Registrar's signature)

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) (Means of injury)

23. Signature James J. Lind (M. D. or other) _____
Address 1545 Lafayette 7/9/45
Date signed

JUL 2 1948

State

Francis J. [unclear]

St. Louis, MO

St. Louis, MO

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

Frank Lee Lee

..... Licensed Embalmer No. *2915*

..... 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.