S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31822

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9349

1. PLACE OF DEATH
(a) County St Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DePaul Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 week (Specify whether years, months or days)
In this community 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 819 Howard (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dominczyk, Veronica
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex FEMALE
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased July (Month) (Day) 1873 (Year)
8. AGE Years 72 Months Days If less than one day hr. min.
9. Birthplace Poland (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name John Kowaleski
13. Birthplace Poland (City, town, or county) (State or foreign country)
14. Maiden name Mary Drawienski
15. Birthplace Poland (City, town, or county) (State or foreign country)
16. (a) Informant Frank Dominczyk
(b) Address 819 Howard
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 30 45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director St Louis Funeral Home
(b) Address 2305 St Louis Ave
19. (a) OCT 29 1945 (Date received by Registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27 year 1945 hour 3 minute 00 P.M.
21. I hereby certify that I attended the deceased from 1-22-44, 19, to 10-26-45, 19; that I last saw her alive on 10-26-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
CANCER - LIVER	
Due to METASTATIC - CANCER CERVICAL - GLANDS - Primary	
Due to HYPERTENTION	
Other conditions (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)
(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 J. R. J. Nowak M.D. (M.D. or other)
Address 1901 Madison St Date signed 10/28/45

844 (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 John Oganoski

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.