

No. 2
-5-43
-5-17-39

FILED NOV 31 1945
Registration District No. **21945**

Primary Registration District No. _____

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

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

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

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. 1538 N 15th Str.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Drezeck, Balbina

3. (b) If veteran, name war _____

3. (c) Social Security No. 489-18-9731

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced W. 2

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept. 16 1897
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
48	1	4	hr. _____ min.

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

10. Usual occupation _____

MOTHER FATHER

11. Industry or business _____

12. Name Martin Kowalczyk

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

14. Maiden name B. Szutkowska

15. Birthplace Poland 11
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Wanda Loch

(b) Address 1538 N 15th Str.

17. (a) Burial (b) Date thereof 10-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

(b) Address 1841 1/2 Cass ave

19. (a) OCT 22 1945 (b) J. F. Drezeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20th
year 1945 hour 11 minute 58 A.M.

21. I hereby certify that I attended the deceased from October 15th 1945, to October 20th 1945, that I last saw her alive on October 20th 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory obstruction

Due to carcinoma of oesophagus 4 mos.

Due to _____

Other conditions 11/2
(Include pregnancy within 3 months of death)

Major findings: oesophagospasm - obstruction due to new growth

Of autopsy not done

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature F. J. Burns (M. D. or other) _____

Address Desloge Hosp. Date signed 10/20/45

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 Tgonoski*
Licensed Embalmer No. *2398*
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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. NovRegistration District No. 318Primary Registration District No. 1003Registrar's No. 9105

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:

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

- (d) Length of stay: In hospital or institution..... (Specify whether

In this community.....
years, months or days)3. (a) PRINT
FULL NAME Drogach, Barbara

3. (b) If veteran,
-
- name war.....

3. (c) Social Security
-
- No.....

4. Sex
- F
5. Color or
-
- race
- w
6. (a) Single, widowed, married,
-
- divorced
- wid

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
-
- alive.....

7. Birth date of deceased
- Sept 16
-
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
-
- 48
- hr. min.

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

10. Usual occupation
- sewness

11. Industry or business

- MOTHER FATHER { 12. Name.....
 { 13. Birthplace..... (City, town, or county) (State or foreign country)
 { 14. Maiden name.....
 { 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

- (b) Address.....

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

- (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

- (b) Address.....

19. (a)
- NOV 13 1945
- J. F. Bredick
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town.....
 (If outside city or town limits, write "RURAL")
 (d) Street No.....
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Nov
-
- year
- 1945
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him/her alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

- Due to.....
-
- Due to.....

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 sta-
tistically.

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.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

31830