

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
#50971
FILED NOV 19 1945
STANDARD CERTIFICATE OF DEATH

State File No. 35507
Registrar's No. 9643

Registration District No. 818
Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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-Max C. Starkloff Memorial
(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 St. Louis 96

(c) City or town Jennings
(If outside city or town limits, write "RURAL")

(d) Street No. 7406 Calvin Ave. ONR
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME RONALD MICHAEL KOZUSZEK

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced ✓

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

7. Birth date of deceased March 8 1941
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5th
year 1945 hour 11:25 minute A M.

21. I hereby certify that I attended the deceased from 11/4/45
to 11/5/45, 19____, to 11/5/45, 19____;
that I last saw him alive on 11/5/45, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death aspiration pneumonia? Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>4</u>	<u>7</u>	<u>27</u>	hr. _____ min. _____

Due to Bulbar poliomyelitis

Due to _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation ✓

Other conditions (Include pregnancy within 3 months of death) z/p 1

Major findings:
Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name Michael K.

13. Birthplace Nashville Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Clara Polozoyowski

15. Birthplace Roanoke Ill.
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Michael K. Kozuszek (Father)

(b) Address 7406 Calvin Ave.

17. (a) Burial (b) Date thereof 11/8/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Edwin F. Price, Jr. (M.D. or other) _____
Address 1515 Lafayette Date signed 11/5/45

18. (a) Signature of funeral director Mark Timmon

(b) Address 6100 W. F. Lorraine

19. (a) NOV 7 1945 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

7
9

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..... *Mark Pierson*

Licensed Embalmer No..... *4174*

P. O. Address..... *6100 W. Flouissant*

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.