

V. S. No. 2  
00M-5-43  
Rev. 5-17-39  
I X36871

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35544

State File No. ....

FILED DEC 12 1945  
318

Primary Registration District No. 1003

Registrar's No. 10484

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4027 Shaw Blvd. /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 59 yrs. (Specify whether years, months or days)

In this community 59 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 4717

(d) Street No. 4027 Shaw Blvd.  
(If rural, give location) 9

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bertha A. Lewandoski

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 W. /

6. (b) Name of husband or wife Joseph Lewandoski 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 1st., 1859  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Dec. day 1st., year 1945 hour 6 minute 35 p. M.

21. I hereby certify that I attended the deceased from 4-25, 1944 to 12-1, 1945.  
that I last saw her alive on 12-1, 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 86 Months 4 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Myocarditis - Chronic

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 92  
(Include pregnancy within 3 months of death)

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Ollie Ollsen 4

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

14. Maiden name Anna Unknown

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Homer Manger

(b) Address 4027 Shaw Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Russell

(b) Address 3840 Lindell Blvd.

19. (a) DEC 3 1945 J. F. Bredeck  
(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? \_\_\_\_\_

23. Signature John Quenler (Specify type of place) (e) Means of injury  
Address 1504 So Grand Date signed 12-3-45

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

17  
9

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. John Duemler  
1504 S. Grand Blvd.

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 Stanley Marshall  
Licensed Embalmer No. 2868  
P. O. Address 3840 Lindell

**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.**