

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED DEC 28 1945 STANDARD CERTIFICATE OF DEATH
1003

38920
State File No. _____
Registrar's No. **11086**

Registration District No. **318** Primary Registration District No. _____

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:
4944 Geneieve Ave /
(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 **Alexander Bialczak**
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, **Married**
6. (b) Name of husband or wife **Rozalie** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept. 19 1897**
(Month) (Day) (Year)

8. AGE: Years **48** Months **2** Days **28** If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business **Parking Attendant**

12. Name **Jan Bialczak**

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

14. Maiden name **Margarete**

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

16. (a) Informant **Rozalie Bialczak**

(b) Address **4944 Geneieve Ave**

17. (a) **Burial** (b) Date thereof **12/20/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery Central Und. Co**

18. (a) Signature of funeral director _____

(b) Address **1841 Cass Ave**

19. (a) **DEC 19 1945** (b) **J. F. Bruck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **000**
(c) City or town **St Louis** 17
(If outside city or town limits, write "RURAL")
(d) Street No. **4944 Geneieve** 9
(If rural, give location)
(e) Citizen of foreign country? **7** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** Day **16** 16th
year **1945** hour **9:55** minute **A**: M.
21. I hereby certify that I attended the deceased from **Feb. 22nd** 19**44** to **Dec 16** 19**45**
that I last saw him alive on **Dec 11th** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cirrhosis hepatis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

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? _____ (c) Means of injury _____
23. Signature **Albert J. M...** (M.D. or other) _____
Address **2739 No 3rd St St. Louis Mo** Date signed **Dec 18 1945**

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

MOTHER FATHER

Lindley C. Blaney

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 Gyoroski*
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.