

FILED MAR 20 1946

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2261**

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

(d) Length of stay: In hospital or institution 1 week (Specify whether years, months or days)

In this community 1 week

3. (a) PRINT FULL NAME Alexander Macarski

3. (b) If veteran, name war No 1 W, war No. 494-109505

3. (c) Social Security

4. Sex male 5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bernice

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased: 5 (Month) 15 (Day) 1885 (Year)

8. AGE: Years Months Days If less than one day

60 9 20 hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

MOTHER FATHER

12. Name John Macarski

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

14. Maiden name Mary Kosciuszka (City, town, or county) (State or foreign country)

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

16. (a) Informant Bernice Macarski

(b) Address 2624 Palm

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-9-46 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director St. Louis Funeral Home

(b) Address 2205 St. Louis Ave

19. (a) MAR 8 1946 (Date received local registrar) (b) J. J. Bredenk (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis

(c) City or town St. Louis 926
(If outside city or town limits, write "RURAL")

(d) Street No. 2624 Palm St (If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th year 1946 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from 2-27-46 to 3-5-46

that I last saw him alive on 3-4-46 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 1 week

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 107

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?

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

23. Signature Albert Kaplan (M.D. or other) Address 607 N. Grand Date signed 3-5-46

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

10365

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 Chas. R. Cadwell

Licensed Embalmer No. 4077

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.