

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11533**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2259**

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:
1808 Warren Street
(If not in hospital or institution, write street number or location)

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

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

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

(d) Street No. **1808 Warren Street**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Victoria Piekutowski**

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

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife **Anthony Piekutowski** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **December 23 1871**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **26th**.
year **1946** hour **3** minute **35** P.M.

21. I hereby certify that I attended the deceased from **February 28th**, 19**46** to **March 6th**, 19**46**, that I last saw her alive on **March 6th**, 19**46**; and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Rheumatic Myocarditis** Duration **10 yrs.**

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

8. AGE: Years **74** Months **2** Days **13** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Anthony Breibish**

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

14. Maiden name **Telegia Karbowski**

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

16. (a) Informant **Mary Baskwend**
(b) Address **1808 Warren Street**

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

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **General Funeral Home**
(b) Address **2233 University**

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

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) (c) Means of injury _____

23. Signature **Walter J. Simon** (M. D. or other) _____
Address **50039 Simon Ave** Date signed **3-8-46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
10445

FILED MAR 1 1946
318

the 8787
4910 Harvard

Dr. W. T. Gunn
5803 Gravois Ave.

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 *Robert J. [Signature]*
Licensed Embalmer No..... 1994

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.