

THE STATE DEPARTMENT OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**FILED DEC 2 1946 318**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

Registrar's No. **9790**

**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: CHRISTIAN HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 DAYS  
(Specify whether)

In this community WIFE  
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. 1815 A.N. 17 STR.  
(If rural, give location)

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

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

**3. (a) PRINT FULL NAME** SUSIE J. BIELICKE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 497-03-6910

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month NOV. day 15<sup>TH</sup>  
year 1946 hour 6:45 minute P. M.

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife JOHN J. BIELICKE

6. (c) Age of husband or wife if alive DEC'D years

7. Birth date of deceased APRIL 14<sup>TH</sup> 1888  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE:  Years 58  Months 7  Days 1  If less than one day  
hr. min.

Duration \_\_\_\_\_

Other conditions Aspiration Pneumonia  
Eye Poisoning Self  
Administered in her home  
Nov. 13, 1946 about 4:30 P.M.

(Include pregnancy within 3 months of death)

9. Birthplace ST. LOUIS MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK (AT HOME)

11. Industry or business FORMERLY BECHT LAUNDRY

MOTHER FATHER { 12. Name UNKNOWN 9

13. Birthplace " " 1

14. Maiden name MARY KRAWIECKI 4

15. Birthplace POLAND 4  
(City, town, or county) (State or foreign country)

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

Of autopsy NO

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Paul E. Bielicki

(b) Address 1815 E. N. 17th St

17. (a) BURIAL (b) Date thereof NOV. 18-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director Brookland and Co

(b) Address 1827 HOGAN STR.

19. (a) NOV 17 1946 (b) J. P. Prudest  
(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) Suicide

(b) Date of occurrence Nov. 13 1946

(c) Where did injury occur? at home  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
None

While at work \_\_\_\_\_ (Specify type of place)

23. Signature Mr. A. J. Perry (M. D. or other) 3

Date signed \_\_\_\_\_

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

---

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.....

Licensed Embalmer No. *4053*

P. O. Address..... *St. Louis, Mo*

**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.