

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

42241  
State File No. 100300  
Registrar's No. 11290

FILED JAN 13 1948

Registration District No. Primary Registration District No. Registrar's No. 11290

1. PLACE OF DEATH:  
(a) County St. Louis Mo.  
(b) City or town St. Louis  
(c) Name of hospital or institution: Shack # 22 3700 S. Main  
(If outside city or town limits, write "RURAL" and name of township)  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County 000  
(c) City or town St. Louis 2411  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3700 S. Main 9  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country

3. (a) PRINT FULL NAME Antoni Chodzinski  
(b) If veteran, name war Maep (c) Social Security No. 0  
5. Color White (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife (c) Age of husband or wife if alive abt. 1871 years  
7. Birth date of deceased (Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Dec day 4 year 1946 hour 11 minute 20 M. 1946  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
abt. 75  
9. Birthplace Ud. Austria (City, town, or county) (Specify foreign country)  
10. Usual occupation the Kunk  
11. Industry or business the Kunk  
12. Name the Kunk  
13. Birthplace the Kunk (City, town, or county) (State or foreign country)  
14. Maiden name the Kunk  
15. Birthplace the Kunk (City, town, or county) (State or foreign country)

Immediate cause of death Lobar Pneumonia  
Due to \_\_\_\_\_  
Due to W. M. 9  
Other conditions (Include pregnancy within 3 months of death) 108

MOTHER FATHER  
16. (a) Informant Thomas F. Callahan  
(b) Address Anatomical Dept  
17. (a) (Burial, cremation, or removal) (b) Date thereof 12-13-46  
(c) Place: burial or cremation Wokington  
18. (a) Signature of funeral director W. J. Bueck  
(b) Address 1200 West  
19. (a) DEC 31 1946 (b) J. F. Bueck  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_  
While at work? (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_  
23. Signature W. J. Bueck (M. D. or other) \_\_\_\_\_  
Address 1200 West Date signed 12/17/46

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

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

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**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.....

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.**