

Registration District No. _____ Primary Registration District No. **6076**

1. PLACE OF DEATH:
 (a) County **St. Louis**
 (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:
Robert Koch Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **31 days**
 (Specify whether _____)

In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **MOO**
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL") **17**
 (d) Street No. **1525 N. 8th**
 (If rural, give location) **9**
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Joseph Peter Puzniak**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex **MO** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife **Single**
 6. (c) Age of husband or wife if alive **Single** years
 7. Birth date of deceased **1 14 1903**
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **6** day **20**
 year **'47** hour **12** minute **33P** M.
 21. I hereby certify that I attended the deceased from **5-**
20, 19**47**, to **6-20**, 19**47**
 that I last saw h. l. m. alive on **6-20**, 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis** Duration **5 yrs.**
 Due to **135**
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **44** Months **6** Days **6** If less than one day _____ hr. _____ min.
 9. Birthplace **St. Louis Mo**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Freight Handler**
 11. Industry or business _____
 12. Name **Mike Puzniak**
 13. Birthplace **Germany**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Catherine Stachler**
 15. Birthplace **Poland**
 (City, town, or county) (State or foreign country)
 16. (a) Informant **Hosp. Records**
 (b) Address **4829 West Florissant Ave.**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 23 '47**
 (Month) (Day) (Year)
 (c) Place of burial or cremation **Calvary Cemetery**
Bronschwig aus Son Funeral Home
 18. (a) Signature of funeral director _____
 (b) Address **4746 W. Florissant Ave.**
 19. (a) **6-24-47** (Date received local registrar) (b) **Robert Koch Hospital** (Registrar's signature) _____
 Address **Robert Koch Hospital** Date signed **6-20-47**

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

23. Signature **William J. Moran** (M. D. or other) **MD**
 Address **Robert Koch Hospital** Date signed **6-20-47**

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

NO REC 11

MOTHER FATHER

96
 0000

JUL 8 1947

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.....

J. W. Wilkinson

Licensed Embalmer No. *3578*

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.