. S. No. 2
0M—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 43571
Registrar's No. 11808

REC'D JAN 9 1948

Registration District No. 818

Primary Registration District No. 1003

**1. PLACE OF DEATH:**

(a) County

(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 Firmin Desloge Hospital
(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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County

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

(d) Street No. 2405 A. Menard St. 23
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME WALASIN, AGNES

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Martin Walasin

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

7. Birth date of deceased June (Month) 18, (Day) 1866 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 6 | 6 | hr. min. |

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Dont Know Walasin
13. Birthplace Lithunia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace Lithunia (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Helen Scheve
(b) Address 2406 A Menard St.

17. (a) S. Burial & Paul (Burial, cremation, or removal) (b) Date thereof 1227-47 (Month) (Day) (Year)
(c) Place: burial or cremation S. S. Peter & paul

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd

19. (a) DEC 26 1947 (Date received local registrar) (b) J. F. Bracca (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month December day 24
year 1947 hour 2 minute 25 P.M.

21. I hereby certify that I attended the deceased from Oct. 1, 1947, to Dec. 24, 1947, that I last saw her alive on Dec. 24, 1947, and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Thrombosis - (repeated) | 4 Months |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations

Of autopsy None

PHYSICIAN

Underline the cause of 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 Fred N. Dungan (M. D. or other) MD
Address 1375 S. Grand Date signed 12/26/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

## 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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3845 Lindell

**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.**