

S. No. 2  
1-1/47  
5-17-39

FEDERAL BUREAU OF INVESTIGATION

National Office of Vital Statistics

FILED FEB 28 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6523

1330

Registration District No. 318

Primary Registration District No. 1005

Registrar's No.

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 3130 N. Jefferson  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... years, months or days)

3. (a) PRINT FULL NAME JOHN IMBIEROWICZ

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

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Stanislawa Imbierowicz  
6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased Dec 17 1873  
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 26 If less than one day hr. min.

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

10. Usual occupation Merchant Grocery + Meat

11. Industry or business Grocery + Meat

12. Name Albert Imbierowicz

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

14. Maiden name unknown

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

16. (a) Informant Stanislawa Imbierowicz

(b) Address 2921 University St.

17. (a) Burial (b) Date thereof 12-16-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director John Imbierowicz

(b) Address 5401 So. Grand Blvd.

19. (a) FEB 4 1948 (b) J. F. Broecker  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County COA  
(c) City or town St. Louis Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2921 University St.  
10 (If rural, give location)  
(e) Citizen of foreign country? f (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2-13-48 day  
year..... hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from 10-6-43, 19..... to 2-1-48, 19.....  
that I last saw him alive on 2-1-48, 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY-SCLEROSIS  
Due to ARTERIO-SCLEROSIS

Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: GH  
Of operations.....  
Of autopsies.....

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?..... (c) Means of injury.....  
3. Signature J. F. Broecker (M. D. or other) MS  
Address 1901 Madison Date signed 2-14-48

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

MOTHER FATHER

*Mil*

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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..... *W W Wilkins*.....  
Licensed-Embalmer-No..... *3575*.....  
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.