

S. No. 3906  
OM-10-47  
v. 5-17-39  
I 3906

#82853  
FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
MAR 11 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2196  
Registrar's No.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County osca  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1533 N 17th 9  
Memorial (If rural, give location)  
(e) Citizen of 26 foreign country? (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ALEX SIMON (Szymanski)  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. 488-03-1742

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 28th  
year 1948 hour 7 minute 20 A. M.  
21. I hereby certify that I attended the deceased from 2/23/48  
1948 to Feb. 28th 1948  
that I last saw h. im alive on Feb. 28th 1948  
and that death occurred on the date and hour stated above.  
Immediate cause of death Intestinal obstruction Duration \_\_\_\_\_

4. Sex M 0 | 5. Color or race W  
6. (a) Single, widowed, married, divorced. M 1  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Sept (Month) 9 (Day) 1889 (Year)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

8. AGE: Years 58 Months 5 Days 19  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Chicago (City, town, or county) Ill 1 (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business General Paper stock Co

12. Name Barney Szymanski

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

14. Maiden name Veronica Jessa

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

16. (a) Informant Chara Szymanski

(b) Address 1533 a N 17th

17. (a) Burial (b) Date thereof 3/2/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cahvary Cemetery

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

(b) Address 1841 Ca ss ave

19. (a) MAR 1 1948 (b) J. F. Prodeck  
(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) \_\_\_\_\_  
(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 Carlyle A. Jones M.D.  
1515 Lafayette (City or town) (State)  
Date signed \_\_\_\_\_

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 Ernest W Spellar

Licensed Embalmer No. 4080

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.**