

FILED JUL 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22119

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1501

1. PLACE OF DEATH

a. COUNTY St. Louis

b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Jennings

c. LENGTH OF STAY (In this place)

2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)

a. STATE Missouri b. COUNTY St. Louis 96

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jennings 0

d. FULL NAME OF HOSPITAL OR INSTITUTION 8824 Scottdale Ave.

d. STREET ADDRESS (If rural, give location) 8824 Scottdale Ave. 0

3. NAME OF DECEASED (Type or Print)

a. (First)

b. (Middle)

c. (Last)

Mary Jakubowski

4. DATE OF DEATH

(Month) (Day) (Year)
May 26, 1949

5. SEX

Female / White

6. COLOR OR RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH

Nov. 14, 1863

9. AGE (In years last birthday)

85 6 12

IF UNDER 1 YEAR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Warsaw, Poland 4

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME

John Borowicka

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME Mrs. Helen Dussold/8824 Scottdale

ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause* (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATION

Cerebral Hemorrhage (Right)

Hypertension

Chronic Myocarditis 33 1/2 year

INTERVAL BETWEEN ONSET AND DEATH

1 hour

2

Typhoid

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. CITY, TOWN, OR TOWNSHIP

(COUNTY)

(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 19, 1949 to May 26, 1949, that I last saw the deceased alive on May 26, 1949 and that death occurred at 7:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE

(Degree or title)

23b. ADDRESS

23c. DATE SIGNED

Anthony C. Prebanter M.D.

1525 a Cass Ave

5-28-49

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

Burial

May 29 1949

Calvary Cemetery

St. Louis, Missouri

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

746 ADDRESS Bromschwig and Son W. Florissant

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

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 MLC

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Sam W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.