Pennsylvania

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6141

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City ST. LOUIS, MO. (No. 4333 N. 19. ST. ..... St. ..... Ward)

File No. ..... Registered No. 1317

2. FULL NAME ANTHONY TORJESKEY.

(a) Residence. No. 4333 N. 19 ST. ..... St., 9 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
MALE	WHITE	MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ANNIE TORJESKEY.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/24/1868/

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	58	11	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work HARNESS MAKER.

(b) General nature of industry, business, or establishment in which employed (or employer) RETIRED.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY.

PARENTS

10. NAME OF FATHER JOHN TORJESKEY.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) GERMANY.

12. MAIDEN NAME OF MOTHER JOSEPHINE KRATZ.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

14. INFORMANT Mrs Annie Torjeskey
(Address) 4333 N. 19th St

15. FILED FEB -7 1927, 19.. Max C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4- 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1926, to Feb 4th, 1928 that I last saw him alive on Feb 3rd, 1928, and that death occurred, on the date stated above, at 10 20 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of stomach

4 to 8

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 44a

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? no. DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? x ray

(Signed) Carl Orth, M. D

Feb 5th, 1928 (Address) 1437 Penrose St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary	2-7- 1927
20. UNDERTAKER	ADDRESS
Provost Und Co	3710 N Grand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.