

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

Do not use this space.

9639

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. St. Johns Hosp.) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 2159

**2. FULL NAME**

Frank Wisniewski  
 (a) Residence, No. 516 East Prairie 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 9, 1901  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
25 3 24  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer.  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Texas

10. NAME OF FATHER John Wisniewski  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Poland.  
 12. MAIDEN NAME OF MOTHER Maggie Schmanski  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Poland.

14. INFORMANT Wm. Bronski  
 (Address) 513 E. Prairie Ave.

15. FILED 11-1-1927 Max C. Staroff  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 3, 1927  
 17. I HEREBY CERTIFY, That I attended deceased from 2/11/27, 19\_\_\_\_, to 3/3/27, 19\_\_\_\_, that I last saw him alive on 3-3-27, 19\_\_\_\_, and that death occurred, on the date stated above, at 5:40 P.M.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:

58 Meloria - Pneumonia  
718 (duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
 CONTRIBUTORY Acute (secondary)  
 (SECONDARY) (duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED Quiphan, Mo.  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? Blood film exam  
 (Signed) W. J. Falk, M. D.  
3/3/27 (Address) University City, Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Quiphan, Mo.  
 DATE OF BURIAL 3/5 1927

20. UNDERTAKER Mullen and Co.  
 ADDRESS 516 S. Delmar St.

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.

