

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.

27 1923

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

Do not use this space.

X  
27911  
226

1. PLACE OF DEATH

County Merion Registration District No. 547  
 Township Merion Primary Registration District No. 3029  
 City St. Elizabeth Hospital (No. St. Elizabeth Hospital Ward)

2. FULL NAME

John W. Gziel  
 (a) Residence No. St. Elizabeth St. St. Elizabeth Ward. St. Elizabeth  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
about 43

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Labour 895  
 (b) General nature of industry, business, or establishment in which employed (or employer) — 785  
 (c) Name of employer Atlas Cement Co. 129

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Old Country

10. NAME OF FATHER Margenie Gziel

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

12. MAIDEN NAME OF MOTHER Sent Endre

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

14. INFORMANT (Address) Mrs. Tony Gziel  
St. Elizabeth

15. FILED 8/27/28 C. E. Stode  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-21-1923

17. I HEREBY CERTIFY, That I attended deceased from ..... , 19....., to ..... , 19....., and that death occurred, on the date stated above, at..... 9:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Probably stroke in brain  
Subarachnoid haemorrhage over cerebral  
apex Aug 14. Recovered from  
that (duration) yrs. mos. 94 da.

CONTRIBUTORY followed stroke over cerebral  
 (SECONDARY) (duration) yrs. mos. 17 da.

18. WHERE WAS DISEASE CONTRACTED Home  
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? yes DATE OF Aug 14

WAS THERE AN AUTOPSY? no

WHAT TESTS CONFIRMED DIAGNOSIS? 2 Symptoms  
 (Signed) E. Haberkamp, M. D.  
 , 19 (Address)

\*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 St. Mary Cemetery DATE OF BURIAL 8-23-1923

20. UNDERTAKER James O'Donnell ADDRESS Hamilton

State of

AGREEMENT TO SETTLE A DISPUTE

1998

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 County Marion Registration District No. 547 File No. 926  
 Township \_\_\_\_\_ Primary Registration District No. 3029 Registered No. \_\_\_\_\_  
 City Hannibal (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Tony Wgick  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. \_\_\_\_\_

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (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) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-21-1928

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Probably abscess in brain  
subdural abscess over  
mastoid  
 (duration) yrs. mos. ds. \_\_\_\_\_  
 CONTRIBUTORY (SECONDARY) Followed abscess over  
mastoid (duration) yrs. mos. ds. \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONCERNED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 , 19\_\_\_\_ (Address) \_\_\_\_\_

\*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.

14. INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

15. FILED 8/27 28 W. C. Shore REGISTRAR  
 19\_\_\_\_

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_  
 20. UNDERTAKER ever ADDRESS \_\_\_\_\_

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**SUPPLEMENTARY**

Probably within Inberuon or Tammale.  
West of their main abodes. Both  
deep imprints of catwalk nature  
G. H. H. H.

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