

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

Do not use this space.

38736

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

11003

City St. Louis Mo. (No.....)

File No.....

Registered No.....

11384

St..... Ward.....

2. FULL NAME Alfred Paul Nowakowsky

(a) Residence, No. 4641 Margarette Aves. 10 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/8/1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 8 13

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer Clerical

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

10. NAME OF FATHER Albert Nowakowsky

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

12. MAIDEN NAME OF MOTHER Fannie Meyer.

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

14. INFORMANT Mrs Marie Nowakowsky
(Address) 4641 Margarette Ave

15. FILED 31 1923 Wm C Stankel
19..... REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/21/28 19

17. I HEREBY CERTIFY, That I attended deceased from August 20, 1928, to Nov 20, 1928, that I last saw him alive on Nov 20, 1928, and that death occurred, on the date stated above, at 10-15 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocardial disease
90 B
Hypertension
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ?

0 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical signs

(Signed) H. H. Felton M. D.

, 19 (Address) 3710 N. Grand

*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

St. Johns Cemetery 11/23/28 19

20. UNDERTAKER ADDRESS

Provoch and Co 3710 N. Grand

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

