

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

Do not use this space.

31730

791

1. PLACE OF DEATH

County.....
Towship.....
City.....

Registration District No. 791
Primary Registration District No. 16th St
(No. Enroute Hosp)

File No.....
Registered No. 9386
St. Ward)

2. FULL NAME TILLIE DZIERBICHA

(a) Residence. No. 1414 N 13 St., 25 Ward.

(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Divorced</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Dzierbicha</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 3-1887</u>		
7. AGE YEARS <u>43</u>	MONTHS <u>4</u>	DAYS <u>24</u>
IF LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 27 1930
 17. I HEREBY CERTIFY, That I attended deceased from 10th Physician in Attendance
 , 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 1 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
Fractures of head
Street with exposed
wound in fight
 CONTRIBUTORY (SECONDARY) Homicide

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

PARENTS

10. NAME OF FATHER	<u>Don't know</u>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)	<u>Don't know</u>
12. MAIDEN NAME OF MOTHER	<u>Don't know</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)	<u>Don't know</u>

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?
 (Signed) Thos V Dewar M.D.
9/29, 1930 (Address) Coroner

14. INFORMANT Helen Schultz
 (Address) 5016 Phoebe

15. FILED SEP 30 1930
Wm J. Hartney
 REGISTRAR

*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 Cobray DATE OF BURIAL Sept 30 1930
 20. UNDERTAKER Central ADDRESS 1841 Casso

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.

