

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

Do not use this space.

0 41024

1. PLACE OF DEATH

County.....*St. Paul Hos.* Registration District No.....*791*
Township..... Primary Registration District No.....*1003*
City..... (No.....) Ward.....

File No.....*11686*
Registered No.....
St..... Ward.....

2. FULL NAME

ANTHONY KAMINSKI
(a) Residence. No.....*5308 ARLINGTON* St., *7* 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Cecilia Kaminski</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>July 11 - 1873</i>		
7. AGE <i>57</i>	YEARS <i>5</i>	MONTHS <i>-</i>
If LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *Loading Clerk*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer. *Burlington R.R.*

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

PARENTS

10. NAME OF FATHER <i>Amey Kaminski</i>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Poland</i>
12. MAIDEN NAME OF MOTHER <i>Leopila Kaminski</i>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Poland</i>

14. INFORMANT *Mrs Cecilia Kaminski*
(Address) *5308 Arlington*

15. FILED *DEC 14 1937*
REGISTRAR *Ray C. Stanley*

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 11 1930*

17. I HEREBY CERTIFY, That I attended deceased from *11-20-30* to *12-11-30*, 19....., to....., 19....., and that I last saw him/her alive on *12-11-30*, 19....., and that death occurred, on the date stated above, at *12-11-30*.....m. *3:30 am*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Stomach
H. 10 B
12 9 (duration) yrs. mos. ds.
CONTRIBUTORY *Pneumonia*
(SECONDARY) (duration) yrs. mos. *6* ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *H. 10 B*

1 DID AN OPERATION PRECEDE DEATH? *No* DATE OF *12-4-30*

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *J.W. Thompson* M. D.
. 19 (Address) *2415 N Kings - Hgw*

*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 <i>Calvary</i>	DATE OF BURIAL <i>Dec 15 1930</i>
20. UNDERTAKER <i>Central</i>	ADDRESS <i>1841 Cass</i>

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.

Build 3 30 AM
Dr. Thompson