

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

Do not use this space.



36168

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St Louis* (No. *Missouri Baptist Hospital*) St. Ward)

File No.....
Registered No. **10693**
St. Ward)

2. FULL NAME

(a) Residence, No. *5916 Theodore* 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 *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 *Elsie Soldinski*

*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 5 - 1894*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
37 0 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Shipping Clerk*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Samuel Shive Co*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St Louis Missouri*

13. NAME *John Soldinski*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

15. MAIDEN NAME *Elizabeth Putski*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT *Elsie Soldinski* (ADDRESS) *5916 Theodore Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary Cemetery* DATE *Oct 23 1931*

19. UNDERTAKER (ADDRESS) *Arthur J. Donnelly, 20380 West 4th*

20. FILED *Oct 21 1931* *May 6 Starkopf* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 19, 1931*

22. I HEREBY CERTIFY, That I attended deceased from *St Louis* *Missouri Baptist Hospital* *St Louis*, 19....., to....., 19.....

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Acute Haemorrhagic Pancreatitis

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) *Wm J Over*

(Address) *Coroner*

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.

