

MAR 13 1939

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

14919
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 1003
 (b) Township St. Louis Primary Registration District No. City Hospital Registered No. 1612
 (c) City St. Louis (d) Street No. City Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

652 Leob Gronkowski
 (a) Residence, No. 5937 Wells St. 6 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-11-1890
 7. AGE YEARS 48 MONTHS 6 DAYS 7 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unemployed
 9. Industry or business in which work was done, as saw mill, bank, etc.
 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 Mo

FATHER 13. NAME John Gronkowski
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Mary Ronas
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Miss Helen Helber
5937 Wells

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE 2/22 39

19. FUNERAL DIRECTOR (ADDRESS) Dulleman
2849 No. Euclid

20. FILED J.F. Brodick Local Registrar.

FEB 20 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-18 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/11, 1939, to 2/18, 1939
 I last saw h.f.m. alive on 1/11, 1939. Death is said to have occurred on the date stated above, at 11:40 a.m.

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

Rheumatic heart disease Date of onset 1/50
 Other contributory causes of importance: 1/50

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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? no
 If so, specify _____
 (Signed) E. D. Munch, M. D.
 (Address) City Hospital #1

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.

1939 FEB - 18 - PM 5 : 00

STATEMENT BY LICENSED EMBALMER

I, Albert Mayfield, Licensed Embalmer No. 3077

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed Albert Mayfield
Licensed Embalmer No. 3077

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)