

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.

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

791  
1003

9300  
Do not use this space.

3065

DEC'D APR 12 1939

1. PLACE OF DEATH

(a) County 3 Registration District No. 1

(b) Township 1 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

(c) City ST. LOUIS (d) Street No. en route City Hospital No. 1 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 352 KONSTANTY STANISZEWSKI

(a) Residence, No. 3225 MONTGOMERY ST. St. 11 (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 MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF \_\_\_\_\_ (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 14TH 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
55 11 15

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. FOMERLY MOOPER  
10. Date deceased last worked at this occupation (month and year) 1929 11. Total time (years) spent in this occupation 20 YRS

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LITHUANIAN

FATHER 13. NAME DONT KNOW 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LITHUANIAN

MOTHER 15. MAIDEN NAME DONT KNOW 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LITHUANIAN

17. INFORMANT (ADDRESS) Justin T. Rutynski, 1800 N. 18th St.

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE APRIL 1ST 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) BROCKLAND UNDCO 1827 HOGAN ST

20. FILED MAR 31 1939 J. B. Pridemore Local Registrar

MEDICAL CERTIFICATE OF DEATH

no attending physician

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 30th 19 39

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 5.45 A.M.

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

Coronary Occlusion;  
Arterio Sclerosis.

Date of onset \_\_\_\_\_

Other contributory causes of importance: AK

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 see above  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) Joseph M. Zimm M.D.  
(Address) Deputy Coroner

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

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

Signed John B. Brockland  
Licensed Embalmer No. # 93  
P. O. Address St. Louis, Mo.

**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.)**

**If this body is not embalmed, above space should be left blank.**