

USE EMERALD BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

SEP 14 1939

791

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27294

Registration District No. 1003

Primary Registration District No.

Registrar's No. 6794

1. PLACE OF DEATH: 1  
(a) County St. Louis, Mo.  
(b) City or town St. Louis, Mo.  
(c) Name of hospital or institution: City Hospital #1  
(d) Length of stay: In hospital or institution 12 hrs.  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED: 1  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis, Mo. [35]  
(d) Street No. 1301 No. 11th St.  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Steve Swiderski. 362  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 486-14-7077

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 3rd year 1939 hour 3:12 minute P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife Eva Swiderski. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 8-14-1887 (Month) (Day) (Year)

Immediate cause of death: Broncho Pneumonia Carcinoma of Esophagus  
Due to \_\_\_\_\_

8. AGE: Years 57 Months 11 Days 18 If less than one day hr. min.

Due to \_\_\_\_\_

9. Birthplace Poland (City, town, or county) (State or foreign country)

Other conditions: \_\_\_\_\_

10. Usual occupation Moulder (City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

11. Industry or business Liberty Foundry Co. 12. Name Steve Swiderski

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

13. Birthplace Poland (City, town, or county) (State or foreign country)

14. Maiden name Mary \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace Poland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joe Swiderski (b) Address 1301 No 11th St

17. (a) Burial (b) Date thereof Aug. 5th-1939 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Central Und. Co. (b) Address 1841 Cass Ave.

19. (a) AUG 4 1939 (b) Registrar's signature

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 4

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Joseph M. [Signature] (Dr. D. or other) \_\_\_\_\_  
Address Deputy Registrar

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**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.....

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

Signed

*J. S. Sullivan*

Licensed Embalmer No. 1123

P. O. Address.....

**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.**