

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

41425

JAN 12 1940 791

Registration District No.

Primary Registration District No.

Registrar's No.

10548

1. PLACE OF DEATH:

(a) County 2  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1824 N. 22 ND. ST.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI, (b) County 1  
(c) City or town ST. LOUIS 20  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1824 N. 22 ND. ST.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8<sup>TH</sup> day DECEMBER,  
year 1939, hour 10:45 PM minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Dec. 8,  
1939, to Dec. 8, 1939  
that I last saw him alive on Dec. 8, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital  
Heart Condition  
Due to Patent Foramen Ovale  
Due to \_\_\_\_\_  
Other conditions Breach Presentation  
(Include pregnancy within 3 months of death)

Duration  
6 1/2  
hours

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

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

3. (a) PRINT FULL NAME JAMES T. BIELICKI

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DECEMBER 8<sup>TH</sup> 1939  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 6 1/2 hr. \_\_\_\_\_ min.

9. Birthplace ST. LOUIS MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name JOHN E. BIELICKI

13. Birthplace ST. LOUIS MO.  
(City, town, or county) (State or foreign country)

14. Maiden name MARY KOMOSINSKI

15. Birthplace ST. LOUIS MO.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John E. Bielicki

(b) Address 1824 N. 22 ND. ST.

17. (a) BURIAL (b) Date thereof DEC. 9<sup>TH</sup> 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Brockland and Co.

(b) Address 1827 HOGAN ST.

19. (a) DEC 9 1939 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

23. Signature Anthony A. Reparski (M. D. or other) MD  
Address 1525 W. Cass Ave Date signed 12/9/39

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.

*No Embalming*

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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 *Guy W Wilkinam*  
Licensed Embalmer No. 3575  
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.**