DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 869

Registration District No. 791 Primary Registration District No. 10[illegible] Registrar's No. 869

FILED FEB 17 1940

1. PLACE OF DEATH:

(a) County

(b) City or town StLouis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day 12 Hrs (Specify whether
In this community 1 Month 21 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 24
(If outside city or town limits, write "RURAL")

(d) Street No. 3332 So Breadway
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ramon Leon Pokojski 22[illegible]

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife No

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December (Month) 9 (Day) 1938 (Year)

8. AGE: Years 1 Months 1 Days 19 If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Casimir Pokojski
13. Birthplace Bottop (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Vera Quick
15. Birthplace Centralia (City, town, or county) Illinois (State or foreign country)

16. (a) Informant's own signature Casimir Pokojski
(b) Address 3332 So. Breadway

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan (Month) 28 (Day) 40 (Year)
(c) Place: burial or cremation Centralia Ill

18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) JAN 29 1940 (Date received local registrar) (b) J. D. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28
year 1940 hour 2 minute 45 A. M.

21. I hereby certify that I attended the deceased from Jan 27 - 40, 1940 to Jan 27th, 1940 that I last saw him alive on Jan 27th, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	3-4 days
Secondary to	
Due to Pertussis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

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

23. Signature L. E. Muhlemann (M.D. or other)
Address 9515 Lafayette Date signed 1/28/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING 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.

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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 L. K. Crapse

Licensed Embalmer No. 3633

P. O. Address 2317 Lakeside

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 869

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(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 _____ (b) County _____

SUPPLEMENTARY

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME RAMON LEON POKOJSKI

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 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 _____ (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

SUPPLEMENTARY

16. (a) Informant's own signature _____
(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Mar. 11, 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Month~~ 28th day of JANUARY year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__;
that I last saw h_____ alive on _____, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchopneumonia pneumococcal	
Due to _____	
Due to _____	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations _____	
Of autopsy _____	

107a

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

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING 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.

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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.....

Licensed Embalmer No.....

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.

February 26, 1940

Mr. E. S. Rosenthal,
Room #10, Muni. Courts Bldg.,
St. Louis, Missouri.

Dear Mr. Rosenthal:

Regarding the cause of death on a certificate for the person of Ramon Leon Pokojski, 3332 So. Broadway, St. Louis, Missouri:

The diagnosis has been changed from Whooping Cough, to Broncho-pneumonia, pneumococcal.

Sincerely,

C. E. Muhlmann

C. E. Muhlmann, M.D.,
St. Louis City Hospital,
St. Louis, Missouri.

CEM:AM