

Registration District No. 791Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH: St. Louis, Mo. 12 1940

(a) County _____

(b) City or town St. Louis, Mo. 1
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 2-1-40 to 2-8-40

3. (a) PRINT, FULL NAME Johanna Szydowski

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

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

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

7. Birth date of deceased November 6- 1919
(Month) (Day) (Year)

8. AGE: Years 20.7 Months 3 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation Sewing

11. Industry or business _____

12. Name Jacob Szydowski

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

14. Maiden name Joanna Szarafinski

15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. Lane

(b) Address 5600 Arsenal

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof 2-10-40
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director St. Louis Funeral Home

(b) Address 2205 St. Louis Ave.

19. (a) FEB 9 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")

(d) Street No. 1849 N. Market
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 2-1-40
_____, 19____, to 2-8-40, 19____;
that I last saw her alive on 2-8-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Bacillary dysentery (Flexner)

Due to _____

Due to _____

Other conditions St. Louis pneumonia, at lower lobe 7 days postpartum
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy none

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? _____

While at work? _____ (Specify type of place)

(a) Means of injury _____

23. Signature D. U. Maxwell (M. D. or other) _____
Address Isolation Hospital Date signed 2/8/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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. Wilkinson

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.