

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.

REG NOV 16 1940  
Registration District No. **7911**

Primary Registration District No. **1003**

Registrar's No. **8483**

**1. PLACE OF DEATH:**  
(a) County.....  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: City Infirmary.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 yrs 3mo. 1 dys  
30 yrs. (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Michael Wrobel.  
**3. (b) If veteran, name war** Unkown  
**3. (c) Social Security No.** Unkown

**4. Sex** Male **5. Color or race** White **6. (a) Single, widowed, married, divorced, Widower**  
**6. (b) Name of husband or wife** NONE **6. (c) Age of husband or wife if alive** NONE years  
**7. Birth date of deceased** September 15 1873.  
(Month) (Day) (Year)

**8. AGE:** Years 67 Months 0 Days 26 If less than one day hr. min.

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

**10. Usual occupation** Laborer. 9

**11. Industry or business** Unknown 9

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

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

**16. (a) Informant's own signature** E Sanders

**(b) Address** 5800 Arsenal St

**17. (a) BURIAL** (b) Date thereof 10-14-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** CALVARY

**18. (a) Signature of funeral director** hullen + Helly

**(b) Address** 1416 N. Fallon and

**19. (a) Date recorded by Registrar** Oct 14 1940 (b) J. B. Bickel  
(Date recorded by Registrar) (Signature)

**2. USUAL RESIDENCE OF DECEASED:**  
Missouri.  
(a) State..... (b) County.....  
(c) City or town St. Louis. 13  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5800 Arsenal St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 30 yrs. years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month October day 10. 1940.  
year 1940 hour 9:20 Am minute M.

**21. I hereby certify that I attended the deceased from** October 9. 1940 to October 10, 1940  
that I last saw him alive on October 10. 1940  
and that death occurred on the date and hour stated above.

**Immediate cause of death** Regenerative Heart Disease  
**Due to** arteriosclerosis  
**Due to** \_\_\_\_\_

**Other conditions** (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 None  
(c) Where did injury occur? (City, town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

**23. Signature** Geo. S. Bazalino, M.D. (M. D. or other)  
**Address** \_\_\_\_\_ **Date signed** \_\_\_\_\_

**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.

*Myself*  
*City License*  
*#145*

Signed *Gleim E. Anderson*

Licensed Embalmer No. *4141*

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.**