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No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

36784
9037

State File No. _____
Registrar's No. _____

Registration District No. **791**

Primary Registration District No. _____

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days
(Specify whether _____)
In this community 36 years
years, months or days)

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. 2116 1/2 N. Fourteenth St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Joseph Zakrewski

3. (b) If veteran, name war none (c) Social Security 488-09-0958

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Anna Zakrewski 6. (c) Age of husband or wife if alive 25 years
7. Birth date of deceased June 21 1904
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>4</u>	<u>10</u>	_____ hr. _____ min.

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

10. Usual occupation press hand

11. Industry or business Multiplex Display Fixture

MOTHER FATHER {
12. Name Peter Paul Zakrewski
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Magdalena Haas
15. Birthplace Nashville Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Zakrewski

(b) Address 2116 1/2 N. Fourteenth St.

17. (a) Burial (b) Date thereof Nov. 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetary

18. (a) Signature of funeral director Brookland

(b) Address 2777 Logan St.

19. (a) NOV 2 1940 (b) _____
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31,
year 1940 hour 10:40 minute _____ P. M.
21. I hereby certify that I attended the deceased from October 29, 1940, to October 31, 1940;
that I last saw him alive on October 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocarditis
Chronic Vascular Disease
Due to of the Heart
(Rheumatic Fever)
Due to _____
Other conditions (Include pregnancy within 3 months of death) Co.
Major findings: None
Of operations _____
Of autopsy None

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?
While at work? _____ (Specify type of place)
(2) Means of injury _____
23. Signature A. Hawley (M. D. certifier)
Address 1515 Lafayette Ave. Date signed 11/1/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Albert H. Happe

Licensed Embalmer No.....

1861

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, fact should be so stated above.