

No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15767

State File No.

Registration District No. 700

Primary Registration District No. 101

Registrar's No. 887

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

In this community 11 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 8804 Manchester Ave.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Michael (Miller) Wojciechowski

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
year 1941 hour 6 minute :30 P.M.

3. (b) If veteran, name war unknown

3. (c) Social Security No. 496-14-2294

21. I hereby certify that I attended the deceased from 4-22-41
19 to 4-24-41 19 ;
that I last saw h. im alive on 4-24-41 19 ;
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, single

Immediate cause of death Cerebral embolus
5 hrs

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

7. Birth date of deceased July 24 1888
(Month) (Day) (Year)

Due to Hypertensive Cardiac
vascular disease 15 yrs.

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>9</u>	<u>0</u>	hr. min.

Due to _____

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

Other conditions (Include pregnancy within 3 months of death) 927

10. Usual occupation Porter

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

11. Industry or business Bernard Gross

MOTHER FATHER { 12. Name Michael Miller

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

{ 14. Maiden name Joanna Mindak

{ 15. Birthplace Chicago Ill.
(City, town, or county) (State or foreign country)

Major findings: Embolus of rt. brachial artery

Of operations _____

Of autopsy _____

16. (a) Informant Mrs Ben Gross

(b) Address 8804 Manchester Rd Brentwood

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof 4-28-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Casuary Cemetery

(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? 707

18. (a) Signature of funeral director Walter H. Papp

(b) Address 1150 N. 1st St

While at work? _____ (Specify type of place)

(e) Means of injury _____

19. (a) APR 25 1941 (b) R. Meyer
(Date received local registrar) (Registrar's signature)

23. Signature L. Kimmman (M. D. or other) M.D.
Address Co. 100 Date signed _____

Licensed Embalmer's Statement on Reverse Side)

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

2
2
3

96
9
1

221

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, fact should be so stated above.