

S. No. 2
A-5-42
5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4030

FILED FEB 21 1943

State File No. _____
Registrar's No. 1372

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County ST. LOUIS MO
(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:
3225 N. FLORISSANT AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 MTHS.
(Specify whether
In this community 50 YRS. (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 000
(c) City or town ST. LOUIS 2617
(If outside city or town limits, write "RURAL") 29
(d) Street No. 2026 MALKINRODT STR.
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country NONE 0

3. (a) PRINT FULL NAME TILLIE CHESNICK
(b) If veteran, NONE name war
(c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month FEB. 9TH day 9TH
year 1943. hour 9:30 minute P. M.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOW.
6. (b) Name of husband or wife BERNARD CHESNICK
6. (c) Age of husband or wife if alive 7 years
7. Birth date of deceased FEB 16TH 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 12 to February 9, 1943
that I last saw h. or alive on Feb 8, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis ()
Duration ()

8. AGE: Years 71 Months 11 Days 23
If less than one day — hr. — min.

Due to _____
Due to _____

9. Birthplace BERBANOVKA 4
(City, town, or county) (State or foreign country)

Other conditions: Had severe respiratory infection Feb 1, 1943
(Include pregnancy within 3 months of death)

10. Usual occupation AT HOME
11. Industry or business HOUSE WORK.

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name SIMON CIECZINSKI.
13. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Agnes England
(b) Address 1827 N. 17th.

17. (a) BURIAL (b) Date thereof FEB. 13-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation CALVARY CEM
18. (a) Signature of funeral director Brockland and Co
(b) Address 1827 Hogan STR.

While at work _____ (Specify type of place)
(c) Means of injury _____
23. Signature Bernard J. Stoll (M. D. or other) _____
Address 2302 Selkirk St Date signed Feb 10 1943

19. (a) FEB 7 (b) J. J. Bredek
(Date received local registrar) (Registrar's signature)

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 W. W. Wilkins
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, fact should be so stated above.