

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

**FILED** OCT 13 1943 318  
 Registration District No.

Primary Registration District No. **1003**

**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:  
1211 WRIGHT  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_ 55 YRS. (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME WALTER YUNG

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 489-16-8571

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARY 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased MARCH 19 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 6 18 hr. \_\_\_\_\_ min.

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

10. Usual occupation RETIRED

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name JOHN

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

14. Maiden name MARY JANKOWSKI

15. Birthplace POLAND  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Yung

(b) Address 1211 WRIGHT ST.

17. (a) BURIAL (b) Date thereof 9-30-43  
(Burial, cremation, or removal) (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) SEP 29 1943 (b) J. F. [Signature]  
(Date received local registration) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County \_\_\_\_\_  
 (c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1211 WRIGHT ST.  
(If rural, give location)  
 (e) Citizen of foreign country? NO. (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 27  
 year 1943 hour 4 minute 58 P.M.

21. I hereby certify that I attended the deceased from Sept 1 1943 to Sept 27 1943  
 that I last saw him alive on Sept 26 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Myocarditis, Phrenitis

Due to + Hypertension

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

Major findings:  
 Of operations 930

Of autopsy \_\_\_\_\_

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)  
 (c) Means of injury \_\_\_\_\_

Signature J. F. [Signature] (M. D. or other)  
 Address 2505 [Address] Date signed 9/29/43

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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.....

*John Gonoski*

Licensed Embalmer No.....

*3398*

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.**