

No. 2
-2-43
-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33049**
Registrar's No. **9099**

Registration District No. **18**
Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri**
(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, A
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Sophia Dymerski**
3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased **October 29 1924**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
18 11 16 hr. min.

9. Birthplace **Springfield Massachusetts**
(City, town, or county) (State or foreign country)

10. Usual occupation **Machine Operator**
11. Industry or business **Ordinance Plant**

12. Name **Jan Dymerski**
13. Birthplace **Unavailable Poland**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Anna Kowalczyk**
15. Birthplace **Unavailable Poland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Jan Dymerski**
(b) Address **35 Talcott, Springfield, Mass**
17. (a) **Removal** (b) Date thereof **10/15/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Springfield, Mass**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**
(b) Address **4700 Washington Blvd.**
19. (a) **OCT 15 1943** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Massachusetts** (b) County **Springfield**
(c) City or town **Springfield, 19**
(If outside city or town limits, write "RURAL")
(d) Street No. **35 Talcott Street., 1 NR**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country **2**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **15**
year **1943** hour **12** minute **10A** M.
21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Diabetes mellitus
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
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) (e) Means of injury.....
23. Signature **Deputy Coroner** (M. D. or other) **3**
Address **Deputy Coroner** Date signed **10/12/43**

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

Charles H. Sasse

Licensed Embalmer No. *1864*

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.