

No. 4-100
-5-43
-17-39
X38671

FILED FEB 1 1944
318

State File No. _____
Registrar's No. 639

Registration District No. _____ Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 38 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MIS. SOURI. (b) County 009
17

(c) City or town ST. LOUIS 110
(If outside city or town limits, write "RURAL")

(d) Street No. 3200 BAILEY AVE.
(If rural, give location)

(e) Citizen of foreign country? REGISTERED ALIEN (Yes or No)
If yes, name country POLAND

3. (a) PRINT FULL NAME Vincent Postawko

3. (b) If veteran, name war _____

3. (c) Social Security No. 494-09-7913

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

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

7. Birth date of deceased August 15 1977
(Month) (Day) (Year)

8. AGE: 66 Years 5 Months 3 Days If less than one day _____ hr. _____ min.

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

10. Usual occupation MOULDER

11. Industry or business FOUNDRY

MOTHER FATHER

12. Name LOUIS POSTAWKO

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

14. Maiden name _____

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

16. (a) Informant Chester Postawko

(b) Address 3837 Maffitt Ave

17. (a) Burial (b) Date thereof 1-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director St. Louis Funeral Home

(b) Address 2225 1944

19. (a) JAN 21 1944 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18th
year 1944 hour 4:05 minute A.M.

21. I hereby certify that I attended the deceased from January 16th 1944, to January 18th 1944, and that death occurred on the date and hour stated above.

that I last saw him alive on January 18th 1944

Immediate cause of death lobar pneumonia

Due to _____

Due to 108

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

Major findings: _____

Of operations _____

Of autopsy Refused

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 108

23. Signature Frank Stanley (M. D. or other) M.D.
Address 1515 Lafayette Date signed 1/18/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Robert Hopper

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.