DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 8 1944

Registration District No. 31

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1083

State File No. 20063

Registrar's No. 5820

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5716 Amelia ave (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County MO
(c) City or town St Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 5716 Amelia (If rural, give location) 9
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Julia Moscicka
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 27 (Day) 1871 (Year)
8. AGE: Years 73 Months 4 Days 1 If less than one day hr. 1 min.
9. Birthplace Poland (City, town, or county) 4 (State or foreign country)
10. Usual occupation
11. Industry or business
12. FATHER Name Domanzak Biedrzycka
13. Birthplace Poland (City, town, or county) (State or foreign country)
14. MOTHER Maiden name Katherine Lojewska
15. Birthplace Poland (City, town, or county) (State or foreign country)
16. (a) Informant Stanley Moscicki
(b) Address 5716 Amelia ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-1-44 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Central Und. Co.
(b) Address 1841 Cass Ave
19. (a) 6-28-44 (Date received local registrar) (b) J. J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28 year 1944 hour 5 minute 45 A.M.
21. I hereby certify that I attended the deceased from June 18, 1944 to June 28, 1944 that I last saw h alive on June 27, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac decompensation	3 da
Due to Sequels of Pneumonia, Lobar	7 da
Due to Information of age	6 mo
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 108
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Francis Conway (M. D. or other) MD
Address 5022 Union Bl Date signed 6/28/44

(Licensed Embalmer's Statement on Reverse Side)

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

5021 Union ave

APR 24 1956

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 by W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
3
36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 5820

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County .....

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

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

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

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Julia Mosacka

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Feb. (Month) 27 (Day) 1871 (Year)

8. AGE: Years 73 | Months 4 | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation At Home

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) JUL 11 1944 (Date received local registrar) (b) J. F. Busick (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June 28
year 1944 hour ..... minute ..... 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.

	Duration
Immediate cause of death	
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?
..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

20063