

FILED DEC 9 1944 18

1003

10303

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5937 Lillian
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 35 years, months or days) (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5937 Lillian
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME

John Deniszczuk
John Deniszczuk

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

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sadie Deniszczuk 6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased 11 10 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 0 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Poland (City, town, or county) (State or foreign country) 4
10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER
12. Name Raymond
13. Birthplace Poland (City, town, or county) (State or foreign country) 4
14. Maiden name Katarzyna Malczewska
15. Birthplace Poland (City, town, or county) (State or foreign country) 4

16. (a) Informant Sadie Deniszczuk
(b) Address 5937 Lillian
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-44 (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) DEC 4 1944 (Date received local Registrar) J. F. Bredich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV 30th day 1944
year 11 hour 05 minute P M.
21. I hereby certify that I attended the deceased from JAN-1942
_____, 19____, to NOV-30-, 1944
that I last saw h. i. m. alive on NOV 30-, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: HAEMORRHAGE-OF-BRAIN
APOPLEXY
CHRONIC ENDOCARDITIS
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 92

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

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 J. F. Bredich (M. D. or other) D. M. W.
Address 1901 Madison St Date signed 12-1-44

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.....

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.