

S. No. 2
M-8-43
v. 5-17-39
X37823

10982

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 12 1945

Registration District No. 818

Primary Registration District No. 2003

Registrar's No. 3865

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:
Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Weeks
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis, '96
(If outside city or town limits, write "RURAL")
(d) Street No. 8502 Hamilton Ave.
(If rural, give location) D.N.R.
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT Full NAME Vincent Barczykowski
(b) If veteran, name war No
(c) Social Security No. 488-09-4439

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 28th
year 1945 hour 10 minute 45 P.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Josephine Barczykowski
6. (c) Age of husband or wife if alive 64 years
March 15th 1876

21. I hereby certify that I attended the deceased from 1/29/45 19 to 4/28/45 19;
that I last saw him alive on 4/28/45 19;
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Thrombosis Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>1</u>	<u>13</u>	hr. _____ min. _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Pittsburgh Pa.
(City, town, or county) (State or foreign country)
10. Usual occupation Grain Inspector

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Unknown
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mrs. Josephine Barczykowski
(b) Address 8502 Hamilton Ave.
17. (a) Burial (b) Date thereof May 2nd 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

(Specify type of place)
While at work? _____ (c) Means of injury _____
23. Signature J. F. Bredet (M. D. or other) MD
Address 6807 W. Florissant Date signed 4/30/45

18. (a) Signature of funeral director Marta Tiernon
(b) Address 6100 W. Florissant Ave.
19. (a) MAY 7 1945 (Date received local registrar)
J. F. Bredet (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

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17
9

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.....

Mark Bernier

Licensed Embalmer No.....

4174

P. O. Address.....

6100 W. Florida

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.