V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

FILED JUL 20 1945

State File No. 21935

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5908

1. PLACE OF DEATH:

(a) County: StvLouis Mo

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

(c) Name of hospital or institution: 901 a Ofalon Str. 1
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DEASCED:

(a) State: Mo. (b) County: 000

(c) City or town: St Louis 17 (If outside city or town limits, write "RURAL") 25

(d) Street No. 901 A Ofalon 9 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: TEOFILIA GARBULSKI

3. (b) If veteran, name war

3. (c) Social Security No. -------

4. Sex: Female 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widow 9

6. (b) Name of husband or wife

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

7. Birth date of deceased: May (Month) 14 (Day) 1894

8. AGE: Years 51 Months 11 Days 20 If less than one day hr. min.

9. Birthplace: Poland (City, town, or county) 4 (State or foreign country)

10. Usual occupation: House wife

11. Industry or business

MOTHER FATHER

12. Name: --- Lapinski

13. Birthplace: Poland (City, town, or county) 4 (State or foreign country)

14. Maiden name: Mary Lapinski

15. Birthplace: Poland (City, town, or county) 4 (State or foreign country)

16. (a) Informant: Stephani Garbulski

(b) Address: 901a Ofallnn

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (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) JUL 7 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4 year 1945 hour 5 minute 55 P.M.

21. I hereby certify that I attended the deceased from May 18, 1945, to July 4, 1945, that I last saw her alive on July 31, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive heart disease — Duration 2 yrs.

Due to: Hypertension

Due to:

Other conditions: Diabetes mellitus — years
(Include pregnancy within 3 months of death)

Major findings:
Of operations: none.

Of autopsy: none.

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): no

(b) Date of occurrence: none

(c) Where did injury occur? none. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none. (Specify type of place)

While at work? no (e) Means of injury: none.

23. Signature: Frank O. Anderson (M.D. or other)

Address: 6409 Enright Ave Date signed 7-5-45

(Licensed Embalmer's Statement on Reverse Side)

Andrews

6409

MAR 18 1946

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 John Ogonoski

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.