

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X34671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21562**
Registrar's No. **1933**

FILED JUN 20 1946
Registration District No. **2106**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
St John's Hospital
(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

3. (a) PRINT FULL NAME **Ben Bronistaw Bromirski**

3. (b) If veteran, name war.....

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

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **3**

6. (b) Name of husband or wife.....

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

7. Birth date of deceased **April 7 1884**
(Month) (Day) (Year)

8. AGE: Years **62** Months **1** Days **24** If less than one day
hr. min.

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

10. Usual occupation **in business**

11. Industry or business **For his self**

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs. Regina Drzewucki**
(b) Address **3724 Darby ave**

17. (a) **Burial** (b) Date thereof **6/5/46**
(Burial, cremation, or removal) (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) **JUN 3 1946** (b) **J. J. Bredick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County.....

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

(d) Street No. **1435 N Market Str.**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **JUNE 1**
year **1946** hour **9** minute **30** AM

21. I hereby certify that I attended the deceased from **MAY 15 1946** to **JUNE 1 1946**,
that I last saw him alive on **JUNE 1 1946**,
and that death occurred on the date and hour stated above.

Immediate cause of death:
ARTERIO SCLEROTIC HEART DISEASE. MYOCARDIAL FAILURE.

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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 **Arthur White** (M. D. or other) **MD**
Address **1194 Kodi Avenue** Date signed **6-2-46**

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

W. 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 with the above constitutes grounds for revocation of license.)

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