

Registration District No. **1946 318**

Primary Registration District No. **1003**

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:
CITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... **1 DAY**
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **CHARLES WYSKOCIL**
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 **DIVORCED**
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **JANUARY 29 1897**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 11 11 hr. min. **1**

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

10. Usual occupation **CLERK**

11. Industry or business **UNION ELECTRIC ST LOUIS MO.**

MOTHER FATHER
12. Name **WILLIAM WYSKOCIL**
13. Birthplace **CZECHOSLOVAKIA**
(City, town, or county) (State or foreign country)
14. Maiden name **MARIA HOLOPIREK**
15. Birthplace **CZECHOSLOVAKIA**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS MARIA YACHOVER**
(b) Address **EDWARDSVILLE, ILL**

17. (a) **REMOVAL** (b) Date thereof **12-12-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **EDWARDSVILLE ILL**

18. (a) Signature of funeral director **ROWLAND SERVICE**
(b) Address **4355 WASHINGTON AV.**

19. (a) **DEC 16 1946** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **ILLINOIS** (b) County **MADISON**
(c) City or town **EDWARDSVILLE**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.R. # 4**
(If rural, give location) **N.R.**
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC** day **10**
year **1946** hour **3** minute **30 P** M.

21. I hereby certify that I attended the deceased from
2....., 19....., to....., 19.....;
that I last saw him..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture of the skull
Extremal Penetration when struck
by a bus operated by one person
Killed which was making a
left hand turn off Market street
into 12th street when the vehicle
signal was in favor of East
bound traffic on Market
Street around 12:15 P.M. Dec 10th**

Other conditions (Include pregnancy within 3 months of death)
Major findings 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) **removed conclusions**
(b) Date of occurrence **Dec 10 - 1946**
(c) Where did injury occur? **27 Jones Ave**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public street

While at work?..... (Specify type of place)
(e) Means of injury **as above**

23. Signature **John E. Dwyer** (Date or other)
Address **1747 N. 4th St** Date signed **12/10/46**

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

MAR 15 1947

10742

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.....

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.