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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2519

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 207

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:
St. Anthony
(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 DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1529 Warren Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Katherine Gawedzinski
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Louis
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November (Month) 23 (Day) 1889 (Year)

8. AGE: Years	Months	Days	If less than one day
57	1	14	hr. min.

9. Birthplace Poland (City, town, or county) 4 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Karol Konopka
13. Birthplace Poland (City, town, or county) 4 (State or foreign country)
MOTHER
14. Maiden name Mary Konopka
15. Birthplace Poland (City, town, or county) 4 (State or foreign country)
16. (a) Informant Louis Gawedzinski
(b) Address 1529 Warren Street
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetary
18. (a) Signature of funeral director Central Und Co.
(b) Address 1841 Cass ave
19. (a) JAN 8 1947 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6th year 1947 hour 8 minute 30 A.M.
21. I hereby certify that I attended the deceased from Jan 2, 1947, to Jan 4, 1947; that I last saw h alive on Jan 3, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic pneumonia	3 days
Due to Heart failure	
Due to Hypertension	
Other conditions Diabetes (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature John F. Michaelree (M. D. or other) M.D.
Address 506 Olive Date signed 8 Jan 47

(Licensed Embalmer's Statement on Reverse Side) (J. F. Michaelree)

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.....J. Allen Davis Jr

Licensed Embalmer No.....4058

P. O. Address.....St Louis Mo

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.