S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 15 1947

Registration District No. .....

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 26150

Registrar's No. 7362

1. PLACE OF DEATH:

(a) County: .....

(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: 1117A. ST. LOUIS, AVE. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: NONE. (Specify whether

In this community: 30 YEARS. years, months or days)

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.: 1117A. ST. LOUIS-AVE. (If rural, give location)

(e) Citizen of foreign country? YES. (Yes or No)

If yes, name country: POLAND.

3. (a) PRINT FULL NAME: KONSTANCYA. TRZASKA.

3. (b) If veteran, name war: NONE

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: STANLEY. TRZASKA. SR.

6. (c) Age of husband or wife if alive: 60 years

7. Birth date of deceased: MARCH (Month) 2ND. (Day) 1887. (Year)

8. AGE: Years	Months	Days	If less than one day
60	5	3	— hr. — min.

9. Birthplace: UNKNOWN (City, town, or county) POLAND (State or foreign country)

10. Usual occupation: HOUSE-WORK (AT HOME.)

11. Industry or business: NONE

FATHER
12. Name: PAWEL. ZAWALICK.
13. Birthplace: UNKNOWN. (City, town, or county) POLAND (State or foreign country)

MOTHER
14. Maiden name: UNKNOWN.
15. Birthplace: UNKNOWN. (City, town, or county) POLAND (State or foreign country)

16. (a) Informant: Stanley Trzaska
(b) Address: 1117A St. Louis Ave

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: AUG. 8th 1947 (Month) (Day) (Year)

(c) Place: burial or cremation: CALVARY CEMETERY.

18. (a) Signature of funeral director: Brookland Und. Co.
(b) Address: 1827-HOGAN-ST.

19. (a) AUG 6 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 5TH year 1947 hour 8 minute 0 A.M.

21. I hereby certify that I attended the deceased from 12 Noon 4 August 1947, to ....., 19..., that I last saw him alive on 12 Noon 4 Aug, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage — Duration: 10 min

Due to: Not known - Lung Carcinoma indicated Hemorrhage

Due to: Brain Tumor

Other conditions (Include pregnancy within 3 months of death): Had not been Patient with Well in the morning one

Major findings: Of operation: Brain Autopsy - Human Kidneys were not there No

Of autopsy: No operations

PHYSICIAN — Underline the cause of 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: 0

23. Signature: Stephen L. McCall (M. D. or other)

Address: 7126 St. Louis Ave. Date signed: 6 Aug 47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.