

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED FEB 9 1948

Registration District No.

318

Primary Registration District No.

Registrar's No.

749

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 **Jewish 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)

2. USUAL RESIDENCE OF DECEASED:

100
Missouri
 (a) State..... (b) County.....
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4735 Minnesota Ave.,**
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Adam J. Mlynarczyk**

3. (b) If veteran, name war **None** 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **22nd**
 year **1948** hour **10** minute **30a** M.

21. I hereby certify that I attended the deceased from **June 1946** to **Jan 22 1948**
 that I last saw him alive on **Jan 22 1948**
 and that death occurred on the date and hour stated above. Duration

Immediate cause of death **Coronary Thrombosis**
Posterior
 Due to **art. sclerosis**
 Due to **gk**
 Other conditions (Include pregnancy within 3 months of death).....

PHYSICIAN

Major findings: Of operations.....
 Of autopsy **Cor. Thromb.**
 Underline the cause of which death should be charged statistically.

4. Sex **Male** 5. Color **white** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Anna Mlynarczyk** 6. (c) Age of husband or wife if alive **46** years
 7. Birth date of deceased **April 15; 1892**
(Month) (Day) (Year)

8. AGE: Years **55** Months **9** Days **7** If less than one day
 hr. min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cabinet Maker**

11. Industry or business.....

12. Name **John Mlynarczyk**

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

14. Maiden name **Katherine Unk.**

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

16. (a) Informant **Mr. John Mlynarczyk**

(b) Address **4700a Pennsylvania**

17. (a) **Burial** (b) Date thereof **1-26-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Olive Cemetery**

18. (a) Signature of funeral director **Southern Funeral Home**

(b) Address **6322 S. Grand Blvd.,**

19. (a) **Jan 26 1948** (b) **J. F. Bredak**
(Date received local certificate) (Registrar's signature)

MOTHER FATHER

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

672

DR. NORMAN W. DREY
~~HEODO GRINE~~
FO 4530

CR 6080

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. W. Binkley

Licensed Embalmer No.

3653

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.