

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

3655

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Christian Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 week  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3923 Ohio Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23  
year 1942 hour 4 minute 10 p. M.

21. I hereby certify that I attended the deceased from April 17-42  
to April 23 42  
that I last saw him alive on April 23 42  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Myelogenous Leukemia  
Non-leukemic  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Andrew H. Kostyshock

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 492-01-6825

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Anna (c) Age of husband or wife if alive 21 years

7. Birth date of deceased: Nov. 16 1905  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>5</u>	<u>7</u>	hr. min.

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

10. Usual occupation Shoe Worker

11. Industry or business International Shoe Co.

MOTHER FATHER { 12. Name Peter Kostyshock  
13. Birthplace Austria  
(City, town, or county) (State or foreign country)  
14. Maiden name Orina Wawrinak  
15. Birthplace Austria  
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Kostyshock  
(b) Address 3923 Ohio Ave.

17. (a) New S.S. P. & P. (b) Date thereof 4/27/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New S.S. P. & P.

18. (a) Signature of funeral director Hubben Benz

(b) Address 2842 Meramec St.

19. (a) ADD 01 1942 (b) J. F. Bullard  
(Date received local Registrar) (Registrar's signature)

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) Means of injury !!

23. Signature J. F. Bullard (M. D. or other) MD  
Address 1143 N. Newstead Date signed April 24 42

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

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**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 Leron E. Percy  
Licensed Embalmer No. 4094

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.**