

Registration District No. **318** Primary Registration District No. **1005** Registrar's No. **6171**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **ST. LOUIS, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **3818 No. 25<sup>TH</sup> ST. 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **42 YEARS**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **000**  
(c) City or town **ST. LOUIS 17**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3818 No. 25<sup>TH</sup> ST. 20**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT

FULL NAME **STANLEY HYDZIK**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **- NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **ANTONETTE HYDZIK** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **APRIL 5 1879**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>66</b>	<b>3</b>	<b>9</b>	hr. _____ min. _____

9. Birthplace \_\_\_\_\_ (City, town, or county) **POLAND** (State or foreign country)

10. Usual occupation **FURNITURE FINISHER**

11. Industry or business **FURNITURE**

12. Name **MICHAEL HYDZIK**

13. Birthplace \_\_\_\_\_ (City, town, or county) **POLAND** (State or foreign country)

14. Maiden name **ANN MICHALOWICZ**

15. Birthplace \_\_\_\_\_ (City, town, or county) **POLAND** (State or foreign country)

16. (a) Informant **ANTONETTE HYDZIK - WIFE**

(b) Address **3818 No. 25<sup>TH</sup> ST.**

17. (a) **BURIAL** (b) Date thereof **7/18/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **B. Kosciuszko**

(b) Address **2205 St. Louis Ave.**

19. (a) **JUL 17 1945** (Date received local registrar) **J. P. Breda** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **14<sup>th</sup>** year **1945** hour **12** minute **45** M.

21. I hereby certify that I attended the deceased from **June 14<sup>th</sup>**, 19**45** to **July 14<sup>th</sup>**, 19**45**

that I last saw him alive on **June 14<sup>th</sup>**, 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute myocarditis**

Due to **chronic gastric ulcer** **Several**  
**pernicious anemia** **years**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **117**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No**

(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) (e) Means of injury \_\_\_\_\_

23. Signature **[Signature]** (M.D. or other) \_\_\_\_\_

Address **2278 S. Jefferson** Date signed **7-16-45**

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

17  
9

MOTHER FATHER

**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.....

*Albert H. Waple*

Licensed Embalmer No.....

*1861*

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.**